SURGERY

TECHNICAL MANUAL

Version 3.0
July 1993

(Revised April 2003)

Department of Veterans Affairs
V*IST***A** System Design & Development

Revision History

The table below lists changes made since the initial release of this manual. Use the Change Pages document to update an existing manual or use the entire updated manual.

Note: The Change Pages document may include unedited pages needed for two-sided copying. Only edited pages display the patch number and revision date in the page footer.

Date	Revised Pages	Patch Number	Description
04/03	Title Page, i, v – vi, 67-69	SR*3*115	- Updated Title page, Revision History, and Table of Contents. - Added new fields TIME OUT VERIFIED and IMAGING CONFIRMED to the SURGERY file (#30) listing; this addition caused the pages to wrap.
02/03	Title Page, I, 15, 69-70, 71, 124, 185	SR*3*107	- Updated Title page and Revision History. - Added new field AUTOMATED CASE CART ORDERING to the SURGERY SITE PARAMETERS file (#133) listing. - Added new fields SPD COMMENTS and DYNAMED NOTIFIED to the SURGERY file (#130) listing; this addition caused the pages to wrap. - Added callable routine CSLSUR1 to the Calls Made by Surgery section.
12/02	185 - 186	SR*3*111	- Added callable routine DGUTL4 to the Calls Made by Surgery section.
11/02	Title Page, i, (ii) 13, (14) (55), 56 (119), 120 (185), 186	SR*3*109	Updated Revision Date and Revision History. - Changed the field name DEFAULT BLOOD REQUEST to DEFAULT BLOOD COMPONENT. - Changed the definition of the field REQ BLOOD KIND from a pointer to the BLOOD PRODUCT file (#66) to a free text field. - Deleted DEFAULT BLOOD REQUEST field, and replaced with DEFAULT BLOOD COMPONENT field. - Added callable routine VBECA5A to the Calls Made by Surgery section.
07/93			Original Release of Technical Manual.

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Preface

The Surgery software package is one segment of the Veterans Health Information Systems and Technology Architecture (**V***IST***A**) software being installed at all VA Medical Centers. This package shares a common source of information, the patient database, with other applications, such as the Pharmacy and Laboratory packages. The basis for information in the Surgery package is the patient record in the computer. Each patient can have information entered about one or more surgical procedures that have occurred.

Table of Contents

Introduction

The Surgery package is designed to be used by Surgeons, Surgical Residents, Anesthetists, Operating Room Nurses and other surgical staff. It is part of the patient information system that stores data on VA patients who have or are about to undergo surgical procedures. This package integrates booking, clinical and patient data to provide a variety of administrative and clinical reports. Patient care is enhanced as managers and clinicians have increased accessibility to more timely and relevant information.

How the Surgery Package is Documented

The Surgery documentation is comprised of three main parts. They are the User Manual, the Installation Guide, and the Technical Manual. The User Manual, Installation Guide, and Technical Manual are written as modular components, each for a different user, and may be distributed independently. The Installation Guide is aimed primarily at package coordinators and site managers. It describes parameters that can be configured to meet the differing needs of individual sites. The Technical Manual and accompanying Release Notes allow the site manager to operate and maintain the software without additional assistance from package developers.

Special Notations

In this manual, the user's response is underlined, but will not appear on the screen underlined. The underlined part of the entry is the letter or letters that must be typed so that the computer can identify the response. In most cases, you need to only enter the first few letters. This increases speed and accuracy.

Every response you type in must be followed by pressing the Return key (or Enter key for some keyboards). Whenever the Return or Enter key should be pressed, you will see the symbol <RET>. This symbol is not shown but is implied if there is underlined input.

Change Pages

Future modifications to the software might require changes to the documentation. Change pages will reflect the new version number and date in the footer. Vertical lines in the margin can also be used to further highlight changes on a page.

Package Management

There are no unique legal requirements for this package. Names and social security numbers used in the examples are fictitious.

How This Software is Organized

The Surgery Software contains seven major components: 1) Requesting and Scheduling, 2) Tracking Clinical Procedures, 3) Generating Surgical Reports, 4) Chief of Surgery Module, 5) Managing the Software Package, 6) Assessing Surgical Risk, and 7) Downloading Transcription.

Requesting and Scheduling. Requests for surgical procedures are entered by the surgeon. These requests are assigned an operating room and time slot by the operating room scheduling manager. The Operating Room Schedule can then be generated automatically on any designated printer in the medical center. The Request and Scheduling module also allows for the rescheduling or cancellation of operative procedures.

Tracking Clinical Procedures. This component is comprised of options used to enter information specific to an individual surgical case. This information includes staff, times, diagnosis, perioperative occurrences, and anesthesia information. The package is designed so that information regarding a case can be entered on a terminal inside the operating room during the actual operative procedure. This information can then be used to generate the Patient Record and Nurse's Intraoperative Report.

Generating Surgical Reports. This section contains management reports for the Surgical Service. Among the reports generated are the Annual Report of Surgical Procedures, Anesthesia AMIS, Attending Surgeons Report, Nurse Staffing Report, and the Laboratory Interim Report.

Chief of Surgery Reporting. This section contains options and reports for the exclusive use of the Service Chief. The Chief has access to lists of cancellations and operations to be dictated, the Morbidity and Mortality Report, and Patient Perioperative Occurrences.

Managing the Software Package. This section contains options designed for the Surgery package coordinator. The package coordinator can configure some of the Surgery fields to conform with the site's needs.

Assessing Surgical Risk. This module provides medical centers a mechanism to track information related to surgical risk and operative mortality. It gives

surgeons an on-line method for evaluating and tracking patient probability of operative mortality. The Risk Assessment Data Manager is the primary user of this section.

Downloading Transcription. This component includes downloading transcriptions of surgical procedures from personal computers onto the **V*IST*A** system. This information can then be merged with the proper case in the SURGERY files.

Menu Outline

Screen displays can vary among different sites and the user might not see the data on their terminal exactly as they appear in this manual. Although screens are subject to modification, the major menu *options*, as they appear in this manual, are fixed and not subject to modifications except by the package developer. The following is a list of the major menu options, and their sub-options, in the order that they appear. A restricted option (Chief's Menu, for example) will not display if you do not have security clearance.

Maintain Surgery Waiting List locked with **SROWAIT**

- Print Surgery Waiting List
- Enter a Patient on the Waiting List
- Edit a Patient on the Waiting List
- Delete a Patient from the Waiting List

Request Operations

- Display Availability
- Make Operation Requests locked with **SROREQ**
- Delete or Update Operation Requests locked with **SROREQ**
- Make a Request from the Waiting List locked with **SROREQ**
- Make a Request for Concurrent Cases locked with **SROREQ**
- Review Request Information
- Operation Requests for a Day locked with **SROREQ**
- Requests by Ward

List Operation Requests

Schedule Operations

- Display Availability
- Schedule Requested Operations locked with **SROSCH**
- Schedule Unrequested Operations locked with **SROSCH**
- Schedule Unrequested Concurrent Cases locked with **SROSCH**
- Reschedule or Update a Scheduled Operation locked with **SROSCH**
- Cancel Scheduled Operation locked with **SROSCH**
- Update Cancellation Reason locked with **SROSCH**
- Schedule Anesthesia Personnel
- Create Service Blockout locked with **SROSCH**
- Delete Service Blockout locked with **SROSCH**
- Schedule of Operations

List Scheduled Operations

Operation Menu locked with **SROPER**

- Operation Information
- Surgical Staff
- Operation Startup
- Operation
- Post Operation
- Enter PAC(U) Information
- Operation (Short Screen)
- Surgeon's Verification of Diagnosis & Procedures locked with **SROEDIT**
- Anesthesia for an Operation Menu locked with **SROANES**
  - Anesthesia Information locked with **SROANES**
  - Anesthesia Technique locked with **SROANES**
  - Medications
  - Anesthesia Report locked with **SROANES**
  - Schedule Anesthesia Personnel
- Operation Report
- Anesthesia Report locked with **SROANES**
- Nurse Intraoperative Report
- Tissue Examination Report
- Enter Referring Physician Information locked with **SROEDIT**
- Enter Irrigations and Restraints locked with **SROEDIT**
- Medications (Enter/Edit)
- Blood Product Verification

Anesthesia Menu locked with **SROANES**

- Anesthesia Data Entry Menu locked with **SROANES**
  - Anesthesia Information (Enter/Edit) locked with **SROANES**
  - Anesthesia Technique (Enter/Edit) locked with **SROANES**
  - Medications (Enter/Edit)
- Anesthesia Report locked with **SROANES**
- Anesthesia AMIS locked with **SROAAMIS**
- Schedule Anesthesia Personnel

Perioperative Occurrences Menu locked with **SROCOMP**

- Intraoperative Occurrences (Enter/Edit)
- Postoperative Occurrences (Enter/Edit)
- Non-Operative Occurrences (Enter/Edit) locked with **SROSURG**
- Update Status of Returns Within 30 Days
- Morbidity & Mortality Reports

Non-O.R. Procedures locked with **SROPER**

Non-O.R. Procedures Menu (Enter/Edit) locked with **SROPER**
Edit Non-O.R. Procedure
Anesthesia Information (Enter/Edit) locked with **SROANES**
Medications (Enter/Edit)
Anesthesia Technique (Enter/Edit) locked with **SROANES**
Procedure Report (Non-O.R.)
Annual Report of Non-O.R. Procedures locked with **SROREP**
Report of Non-O.R. Procedures locked with **SROREP**

Comments locked with **SROPER**

Surgery Reports locked with **SROREP**

Management Reports
Schedule of Operations
Annual Report of Surgical Procedures
List of Operations
List of Operations (by Postoperative Disposition)
List of Operations (by Surgical Specialty)
List of Operations (by Surgical Priority)
Report of Surgical Priorities
List of Undictated Operations
Report of Daily Operating Room Activity
PCE Filing Status Report
Outpatient Encounters Not Transmitted to NPCD
Surgery Staffing Reports
Attending Surgeon Reports
Surgeon Staffing Report
Surgical Nurse Staffing Report
Scrub Nurse Staffing Report
Circulating Nurse Staffing Report
Anesthesia Reports
Anesthesia AMIS locked with **SROAAMIS**
List of Anesthetic Procedures
Anesthesia Provider Report locked with **SROANES**
CPT Code Reports
Cumulative Report of CPT Codes
Report of CPT Coding Accuracy
List Completed Cases Missing CPT Codes

Laboratory Interim Report

Chief of Surgery Menu locked with **SROCHIEF**

- View Patient Perioperative Occurrences
- Management Reports
  - Morbidity & Mortality Reports
  - M&M Verification Report
  - Comparison of Preop and Postop Diagnosis
  - Delay and Cancellation Reports
    - Report of Delayed Operations
    - Report of Delay Reasons
    - Report of Delay Time
    - Report of Cancellations
    - Report of Cancellation Rates
  - List of Unverified Surgery Cases
  - Report of Returns to Surgery
  - Report of Daily Operating Room Activity
  - List of Undictated Operations
  - Report of Cases Without Specimens
  - Report of Unscheduled Admissions to ICU
  - Operating Room Utilization Report
  - Wound Classification Report
  - Quarterly Report Menu locked with **SROCHIEF**
    - Quarterly Report - Surgical Service
    - Deaths Within 30 Days of Surgery
    - Admissions Within 14 Days of Outpatient Surgery
    - List of Invasive Diagnostic Procedures
    - List of Operations Included on Quarterly Report
    - Report of Missing Quarterly Report Data
  - Print Blood Product Verification Audit Log
- Unlock a Case for Editing
- Update Status of Returns Within 30 Days
- Update Cancelled Case locked with **SROCHIEF**
- Update Operations as Unrelated/Related to Death
- Update/Verify Procedure/Diagnosis Codes

Surgeons' Dictation Menu

- Enter/Edit Date of Dictation locked with **SROTRAN**
- List of Untranscribed Surgeon's Dictation
- Undictated Operations locked with **SROSURG**

Surgery Package Management Menu locked with **SRCOORD**

Surgery Site Parameters (Enter/Edit)
Operating Room Information (Enter/Edit)
Surgery Utilization Menu locked with **SRCOORD**
    Operating Room Utilization (Enter/Edit)
    Normal Daily Hours (Enter/Edit)
    Operating Room Utilization Report
    Report of Normal Operating Room Hours
    Purge Utilization Information
Person Field Restrictions Menu
    Enter Restrictions for 'Person' Fields
    Remove Restrictions for 'Person' Fields
Update O.R. Schedule Devices
Update Staff Surgeon Information
Flag Drugs for Use as Anesthesia Agents
Update Site Configurable Files
Backfill Order File with Surgical Cases locked with **SRCOORD**
Surgery Interface Management Menu
    Flag Interface Fields
    File Download
    Table Download
    Update Interface Parameter Field

Surgery Risk Assessment Menu locked with **SR RISK ASSESSMENT**

Non-Cardiac Risk Assessment Information (Enter/Edit)
    Preoperative Information (Enter/Edit)
    Laboratory Test Results (Enter/Edit)
    Operation Information (Enter/Edit)
    Patient Demographics (Enter/Edit)
    Intraoperative Occurrences (Enter/Edit)
    Postoperative Occurrences (Enter/Edit)
    Update Status of Returns Within 30 Days
    Update Assessment Status to 'COMPLETE'
Cardiac Risk Assessment Information (Enter/Edit)
    Clinical Information (Enter/Edit)
    Enter Cardiac Catheterization & Angiographic Data
    Operative Risk Summary Data (Enter/Edit)
    Cardiac Procedures Requiring CPB (Enter/Edit)
    Intraoperative Occurrences (Enter/Edit)
    Postoperative Occurrences (Enter/Edit)
    Resource Data

Update Assessment Status to 'COMPLETE'
Print a Surgery Risk Assessment
Update Assessment Completed/Transmitted in Error
List of Surgery Risk Assessments
Print 30 Day Follow-up Letters
Exclusion Criteria (Enter/Edit)
Monthly Surgical Case Workload Report
Update Operations as Unrelated/Related to Death
M&M Verification Report
Update 1-Liner Case
Queue Assessment Transmissions

CPT/ICD9 Coding Menu locked with **SR CODER**

CPT/ICD9 Update/Verify Menu locked with **SR CODER**
Update/Verify Procedure/Diagnosis Codes
Operation/Procedure Report
Nurse Intraoperative Report
Cumulative Report of CPT Codes
Report of CPT Coding Accuracy
List Completed Cases Missing CPT Codes
List of Operations
List of Operations (by Surgical Specialty)
List of Undictated Operations
Report of Daily Operating Room Activity
PCE Filing Status Report
Report of Non-O.R. Procedures

Surgery Transcriptionist's Menu

Transmit Transcribed Operation Notes
Batch Print Transcripted Operation Notes
List Operation Notes in the 'Print' Queue
List of Unmerged Operation Notes
Transcribe Surgeon's Dictation (FileMan)
Enter/Edit Date of Dictation locked with **SROTRAN**

Implementation and Maintenance

Installation

For installation of the Surgery V. 3.0 software package, please refer to the Installation Guide.

Site Specific Parameters

Before the Surgery package can be used, some initial information must be set up as follows:

1. NEW PERSON File

All personnel (surgeons, anesthesiologists, nurses, etc.) must be properly defined in the NEW PERSON file (#200).

2. Security Keys

Security keys have various uses in the Surgery package and must be assigned as needed before using the package. The security keys used by the Surgery package are described in the Security Key section of this manual.

3. Surgery Site Parameters

There are a number of fields contained in the SURGERY SITE PARAMETER file (#133), which can be updated locally. These fields are described below. The Surgery Package Management Menu contains an option to facilitate editing.

MAIL CODE FOR ANESTHESIA: This represents the mail code for the Anesthesiology Service at your facility. The information entered in this field is used by the software to assign the anesthetist category for the principal anesthetist on a case.

CANCEL IVS: If set equal to YES, all active IV orders will be canceled when a surgical case begins.

DEFAULT BLOOD COMPONENT: If your facility uses a certain type of blood component for most surgical cases, you can enter that blood component in this field. The component will show up as a default when requesting blood.

CHIEF OF SURGERY: This is the name of the Chief of Surgery. The name will appear on the schedule of operations in the format entered here.

LOCK AFTER HOW MANY DAYS: This field determines how many days a surgical case remains unlocked after completion. Editing information related to a surgical case is prohibited after a case has been locked.

REQUEST DEADLINE: This is the time of day that requests are no longer accepted for the next available day. This field is used along with the Request Cutoff fields explained in this section.

SCHEDULE CLOSE TIME: This is the time of day that the schedule will be closed for the upcoming day. It will be used to determine whether canceled cases will appear on the cancellation report. Cases canceled before this time will not be counted as cancellations and will be deleted from the system. The SCHEDULE CLOSE TIME cannot be later than 3:00 pm.

NURSE INTRAOP REPORT: This field determines which format is used when printing the Nurse Intraoperative Report. One format prints all field titles, even when there is no data associated with the field. The other only prints those field titles that have information entered.

OPERATION REPORT FORMAT: This field determines which format is used when printing the Operation Report. One format prints all field titles, even when there is no data associated with the field. The other only prints those fields that have information entered.

RISK ASSESSMENT IN USE (Y/N): This field is no longer in use, but was once used to determine whether your facility was involved in the VA Surgical Risk Study.

ASK FOR RISK PREOP INFO: This field is used to determine if the user should be prompted for risk assessment preoperative information when entering a new case and when updating a requested or scheduled case.

UPDATES TO PCE: This field indicates the site's preference for PCE updating. If this field contains O, PCE will be updated with outpatient case information only. If this field contains A, PCE will be updated information from all cases, both inpatient and outpatient. If this field contains N or is null, no PCE updating will occur.

PCE UPDATE ACTIVATION DATE: This is the earliest date of operation for which surgical cases may be filed with PCE. Surgical cases or non-OR procedures performed before this date will not be filed with PCE. If no date is entered, this parameter will be ignored.

ASK CLASSIFICATION QUESTIONS: This field indicates whether the patient service connected classification questions should be asked when entering a new case or when updating an existing case.

SURGICAL RESIDENTS (Y/N): This field indicates whether surgery may be performed by residents at this facility. Enter NO if all surgeons at this facility are staff surgeons. If this field is NO an attending surgeon will not be required by the PCE interface and cases with no attend code will be counted as Level 0 (Staff Alone) on the Quarterly Report.

REQUIRED FIELDS FOR SCHEDULING: With Surgery V. 3.0, you can prohibit the scheduling of a surgical case until certain fields have been entered. This "multiple" field will contain any fields that are required prior to scheduling a procedure. For example, if you want to make the principal operative code (CPT) mandatory for scheduling, enter that field name here. Since this is a multiple field, you can restrict scheduling dependent on more than one field. Fields that are themselves multiple fields or that are word-processing fields cannot be selected.

REQUEST CUTOFF FOR SUNDAY: This field determines which day of the week is the cutoff day for requesting cases for Sunday. For example, if the cutoff day is Friday, you will be unable to request cases for Sunday after the request deadline on Friday. You can also make Sunday inactive, prohibiting requests entirely.

These fields function similar to the REQUEST CUTOFF FOR SUNDAY field:

REQUEST CUTOFF FOR MONDAY
REQUEST CUTOFF FOR TUESDAY
REQUEST CUTOFF FOR WEDNESDAY
REQUEST CUTOFF FOR THURSDAY
REQUEST CUTOFF FOR FRIDAY
REQUEST CUTOFF FOR SATURDAY

HOLIDAY SCHEDULING ALLOWED: This field determines which holidays have surgical cases scheduled. This information must be updated each year for all holidays.

INACTIVE?: This field is used to make a division inactive and to prevent its selection and use by Surgery users.

AUTOMATED CASE CART ORDERING: This field indicates whether or not the CoreFLS interface is in use at the facility. You can enter YES, NO, or leave the field blank.

4. Options Tasked Daily

SRTASK-NIGHT This option initiates a number of background tasks to cleanup the surgery database and update all appropriate information. Among the tasks performed are calculation of average procedure times, cleanup ofoutstanding requests, update expected start and end times for operating rooms, locking cases, transmit risk assessment and workload information, transmit Quarterly Reports, and send updates to PCE.

SRTASK-BATCH OP REPORTS This option automatically prints the operation reports for completed cases on the previous day.

5. HOSPITAL LOCATION/ OPERATING ROOM Files

The operating rooms must be added to two VA FileMan files before they can be used in any of the Surgery package applications: HOSPITAL LOCATION (File 44) and OPERATING ROOM (File 131.7). All locations for non-O.R. procedures must be defined in the HOSPITAL LOCATION file (#44).

HOSPITAL LOCATION File (#44):

Below is an example of how to set up an operating room in the HOSPITAL LOCATION file. Please coordinate entries with the MAS package coordinator.

Example: Setting Up Operating Room in HOSPITAL LOCATION File

```
Select VA FileMan Option: Enter or Edit File Entries

INPUT TO WHAT FILE: HOSPITAL LOCATION
EDIT WHICH FIELD: ALL//  <RET>

Select HOSPITAL LOCATION NAME: OR1
  ARE YOU ADDING 'OR1' AS A NEW HOSPITAL LOCATION (THE 24TH)? Y  (YES)
   HOSPITAL LOCATION TYPE: OR   OPERATING ROOM
   HOSPITAL LOCATION TYPE EXTENSION: OPERATING ROOM//  <RET>
ABBREVIATION: OR1
TYPE: OPERATING ROOM//  <RET>
TYPE EXTENSION: OPERATING ROOM//  <RET>
INSTITUTION: BIRMINGHAM, AL.  [Very important at multi-division medical centers.]
DIVISION: ^
```

[It is unnecessary to enter any other fields in this file. Enter an up arrow (^) to exit.]

OPERATING ROOM File (#131.7)

All operating rooms must also be defined in the OPERATING ROOM file (#131.7). Below is an example of how to set up an operating room in the OPERATING ROOM file.

The *Surgery Utilization Menu* option in the Surgery Package Management Menu has a sub-option called *Normal Daily Hours (Enter/Edit)* for editing operating room normal daily hours. The *Operating Room Information (Enter/Edit)* option in the Surgery Package Management Menu can be used to edit other information in this file.

Note: The operating rooms will appear on the Schedule of Operations in the same sequence in which they are entered in this file.

Example: Setting Up an Operating Room in OPERATING ROOM File

```
Select VA FileMan Option: Enter or Edit File Entries

INPUT TO WHAT FILE: OPERATING ROOM
EDIT WHICH FIELD: ALL//  <RET>

Select OPERATING ROOM NAME: OR1
  ARE YOU ADDING 'OR1' AS A NEW OPERATING ROOM (THE 1ST)? Y  (YES)
LOCATION: THIRD FLOOR NORTH WING
PERSON RESP.: MOODY,JUDY TRUDY
TELEPHONE: EXT 5244
REMARKS:  <RET>
TYPE: ?
 ANSWER WITH OPERATING ROOM TYPE NAME
 DO YOU WANT THE ENTIRE 13-ENTRY OPERATING ROOM TYPE LIST? Y  (YES)
CHOOSE FROM:
   AMBULATORY OPERATING ROOM
   CARDIAC OPERATING ROOM
   CARDIAC/NEURO OPERATING ROOM
   CLINIC
   CYSTOSCOPY ROOM
   DEDICATED ROOM
   ENDOSCOPY ROOM
   GENERAL PURPOSE OPERATING ROOM
   INTENSIVE CARE UNIT
   NEUROSURGERY OPERATING ROOM
   ORTHOPEDIC OPERATING ROOM
   OTHER LOCATION
   WARD
TYPE: GENERAL PURPOSE OPERATING ROOM
CLEANING TIME: 30
Select DAY OF THE WEEK: SUNDAY
  ARE YOU ADDING 'SUNDAY' AS A NEW DAY OF THE WEEK (THE 1ST FOR THIS OPERATING
ROOM)? Y  (YES)
  NORMAL START TIME:  <RET>
  NORMAL END TIME:  <RET>
  INACTIVE (Y/N): YES
Select DAY OF THE WEEK: MONDAY
  ARE YOU ADDING 'MONDAY' AS A NEW DAY OF THE WEEK (THE 2ND FOR THIS OPERATING
ROOM)? Y  (YES)
  NORMAL START TIME: 07:00
  NORMAL END TIME: 15:30
  INACTIVE (Y/N):  <RET>
Select DAY OF THE WEEK: TUESDAY
```

```
  ARE YOU ADDING 'TUESDAY' AS A NEW DAY OF THE WEEK (THE 3RD FOR THIS OPERATING
ROOM)? Y  (YES)
  NORMAL START TIME: 07:00
  NORMAL END TIME: 15:30
  INACTIVE (Y/N):  <RET>
Select DAY OF THE WEEK: WEDNESDAY
  ARE YOU ADDING 'WEDNESDAY' AS A NEW DAY OF THE WEEK (THE 4TH FOR THIS OPERATING
ROOM)? Y  (YES)
  NORMAL START TIME: 07:00
  NORMAL END TIME: 15:30
  INACTIVE (Y/N):  <RET>
Select DAY OF THE WEEK: THURSDAY
  ARE YOU ADDING 'THURSDAY' AS A NEW DAY OF THE WEEK (THE 5TH FOR THIS OPERATING
ROOM)? Y  (YES)
  NORMAL START TIME: 07:00
  NORMAL END TIME: 15:30
  INACTIVE (Y/N):  <RET>
Select DAY OF THE WEEK: FRIDAY
  ARE YOU ADDING 'FRIDAY' AS A NEW DAY OF THE WEEK (THE 6TH FOR THIS OPERATING
ROOM)? Y  (YES)
  NORMAL START TIME: 07:00
  NORMAL END TIME: 15:30
```

```
INACTIVE (Y/N):  <RET>
```

```
  ARE YOU ADDING 'SATURDAY' AS A NEW DAY OF THE WEEK (THE 7TH FOR THIS OPERATING
ROOM)? Y  (YES)
  NORMAL START TIME:  <RET>
  NORMAL END TIME:  <RET>
  INACTIVE (Y/N): YES
INACTIVE?:  <RET>
```

6. Adding Entries to Surgery-Related Files

There are several site configurable Surgery files, which may need updating to add new entries or to inactivate or change existing entries. These configurable files are listed below. The Update Site Configurable Files option on the Surgery Package Management Menu can be used to update these files.

Surgery Transportation Devices
Surgery Positions
Surgery Delay
Irrigations
Surgery Cancellation Reason
Skin Integrity
Patient Consciousness
Electroground Positions
Prosthesis
Restraints and Positional Aids
Monitors
Surgery Replacement Fluids
Skin Prep Agents
Patient Mood
Local Surgical Specialty
Surgery Dispositions

7. Flag Drugs for Anesthesia Agents

Drugs to be used as anesthesia agents must be flagged,or else they cannot be selected as entries in the ANESTHESIA AGENT data fields.

8. Mail Groups

There are two mail groups that should be created with the appropriate persons added as members:

SR-QUARTERLY
RISK ASSESSMENT
SRHL DISCREPANCY

See the Installation Guide for instructions on setting up these mail groups.

Security Keys

There are 23 security keys in the Surgery package. Most are used to restrict access to certain options within the package. Other keys can be used to restrict which people can be entered in specific fields. This section of the manual describes each key. These descriptions can aid the package coordinator in assigning security levels to the user personnel. A list of users' names and security key levels must be supplied to the site manager.

The following keys are used to determine whether a person can be entered in a specific field. Version 3.0 of the Surgery package allows you to restrict entries for any "person" type field based on keys. For example, you could restrict entries into the SURGEON (.14) field in the SURGERY (130) file to only those people who are holders of the SR SURGEON key. When entering data for a surgical case, only those people can be selected as a surgeon. Restriction of fields is not limited to the keys listed below. You can use any existing key, or create keys of your own, to restrict access. The keys listed below are supplied for your convenience. If you do not choose to restrict "person" type fields, these keys will not be used elsewhere in the Surgery package.

SR ANESTHESIOLOGIST: This key is used to restrict entry into selected fields in which an anesthesiologist can be entered.

SR MED STUDENT: This key is used to restrict entry into selected fields in which a medical student can be entered.

SR NURSE: This key is used to restrict entry into selected fields in which a nurse can be entered.

SR NURSE ANESTHETIST: This key is used to restrict entry into fields in which a nurse anesthetist can be entered.

SR PHYSICIAN ASSISTANT: This key is used to restrict entry into fields in which a physician assistant can be entered.

SR SURGEON: This key is used to restrict entry into fields in which a surgeon can be entered.

The following keys are used to restrict access to menus and options. Only holders of these keys will be permitted to access the locked options or functions.

SR CODER: This key should be given to those responsible for entering CPT and ICD9 codes for operations and non-OR procedures. This key is used to lock the Surgery CPT/ICD9 Update/Verify Menu.

SR REQ OVERRIDE: This key allows users to make operation requests beyond the site selected cutoff times. The SR REQ OVERRIDE key should only be given to those users that are permitted to make this type of last minute request.

SR RISK ASSESSMENT: This key is used to lock the Surgery Risk Assessment Menu and all the options it contains. The SR RISK ASSESSMENT key should be given to the Surgery Risk Data Manager and Surgery Application Coordinator.

SR STAFF SURGEON: This key is used to determine whether a person is a staff surgeon.

SRCOORD: This key is used to lock the Surgery Package Management Menu and the options it contains. The SRCOORD key should be given to the Surgery Application Coordinator.

SROAAMIS: This key is required when accessing the Anesthesia AMIS option [SROAMIS] and should be given to only those users that will need to print the Anesthesia AMIS report.

SROANES: This key is required when accessing any anesthesia related option, with the exception of the Anesthesia AMIS option, which has its own unique key.

SROCHIEF: This key is required when accessing the Chief of Surgery Menu and the options it contains. The SROCHIEF key should be given to the Surgery Application Coordinator, Chief of Surgery, and his or her designee.

SROCOMP: This key is used to lock the Complications Menu. It should be given to those users permitted to enter, edit, and delete surgical complications.

SROEDIT: This key is required when entering or editing Surgery related data. hen entering or editing Surgery related data. Users that do <u>not</u> have this key are limited to viewing access, rather than editing access, on all Surgery screens.

SROPER: This key is required to access the Operations menu [SROPER] and all options it contains.

SROREP: This key is required when accessing the Surgery Reports option [SRORPTS]. Options in this menu cannot be accessed without this key.

SROREQ: This key is required when accessing the Request Operations menu [SROREQ], and is given only to those users responsible for making requests.

SROSCH: This key is required when accessing the Schedule Operations menu [SROSCHOP], and is given only to users responsible for scheduling operations.

SROSURG: This key is required when accessing the options Undictated Operations [SRODICT] and Enter/Edit Non-Operative Complications [SROCOMP].

SROTRAN: This key is required when accessing the Transcribe Doctor's Dictation option [SRSTRAN] and the Enter/Edit Date of Dictation option [SROCHDD]. It is given to those users responsible for transcription and/or entering the date of dictation. The Transcriptionist's Menu and options within it are also locked with SROTRAN.

SROWAIT: This key is required when accessing the Maintain Surgery Waiting List option. Only users responsible for adding, changing, deleting, or printing data on the waiting list are given this key.

File Security

The following files are distributed with limited access. Files not listed below are sent without restrictions on VA FileMan access. Sites can add their own file access codes as needed, but it is highly recommended that they do not change the codes that are sent with this software package.

PERSON FIELD RESTRICTION (131)

READ	@
WRITE	^
DELETE	^
LAYGO	@

ANESTHESIA SUPERVISOR CODES (132.95)

WRITE	^
DELETE	^
LAYGO	^

OPERATING ROOM TYPE (134)

WRITE	^
DELETE	^
LAYGO	^

SURGERY TRANSCRIPTION (136)

READ	@
WRITE	^
DELETE	^
LAYGO	^

COMPLICATION CATEGORY (136.5)

READ	^
WRITE	^
DELETE	^
LAYGO	^

MEDICAL SPECIALTY (723)

READ	@
WRITE	@
DELETE	@
LAYGO	@

Files

SURGERY (130)

Each entry in the SURGERY file contains information regarding a surgery case made up of an operative procedure, or multiple operative procedures, for a patient. The file includes the information necessary for creating the Nurses' Intraoperative Report, Operation Report, and Anesthesia Report.

.01 PATIENT POINTER
This is the name of the patient.

.011 IN/OUT-PATIENT STATUS SET
This field contains the patient's hospital admission status at the time of surgery. Enter the letter "I" if the patient is an inpatient or the letter "O" if he or she was an outpatient.

.015 VISIT POINTER
This is the visit associated with this case.

.0155 CLASSIFICATION ENTERED (Y/N) SET
This field indicates whether or not classification items have been addressed. This field is used by the software to decide whether to allow the user a choice to update classification information. If the field is NO or null, it will not permit a choice if the site parameter to enter classification information is turned on.

.016 SERVICE CONNECTED SET
This field will be used to indicate if this surgery or non-OR procedure is treating a VA patient for a service-connected problem. This information may be passed to the VISIT file (#9000010).

.017 AGENT ORANGE EXPOSURE SET
This field will be used to indicate if this surgery or non-OR procedure is treating a VA patient for a problem that is related to Agent Orange Exposure. This information may be passed to the VISIT file (#9000010).

.018 IONIZING RADIATION EXPOSURE SET
This field will be used to indicate if this surgery or non-OR procedure is treating a VA patient for a problem that is related to Ionizing Radiation Exposure. This information may be passed to the VISIT file (#9000010).

.019 ENVIRONMENTAL CONTAMINANTS SET

This field will be used to indicate if this surgery or non-OR procedure is treating a VA patient for a problem related to environmental contaminant exposure. This information may be passed to the VISIT file (#9000010).

.02 OPERATING ROOM POINTER
This is the name of the operating room where the principal operation is performed for this patient. It can be selected by entering the name or abbreviation of the operating room.

.021 ASSOCIATED CLINIC POINTER
This is the clinic associated with this surgical case or non-OR procedure. The entry made in this field will be used as the location of the encounter for PCE.

.03 MAJOR/MINOR SET
Major - Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.

Minor - All operations not designated as Major.

.035 CASE SCHEDULE TYPE SET
This is the code describing how this case was scheduled. It is important that this field is entered. The Scheduler may use this field when updating the schedule due to cancellations or insertions.

.037 CASE SCHEDULE ORDER FREE TEXT
This is the sequence in which the surgeon expects to do the case if he or she has more than one case scheduled for this day. This field is optional, but is very useful to the person scheduling cases if the surgeon has more than one case.

.04 SURGERY SPECIALTY POINTER
This is the surgical specialty credited for doing this operative procedure. Many reports, including the Annual Report of Surgical Procedures, are sorted by the surgical specialty. This field should be entered prior to completion of this case.

.05 REQ CLEAN OR CONTAMINATED SET
This is the description of the wound class for the case. The code entered is used when scheduling the operating room for this procedure.

.07 PREOP SKIN INTEG POINTER

This is the preoperative assessment of the patient's skin integrity upon arrival to the operating room. The information entered will appear on the Nurse Intraoperative Report.

.08 PREOP SKIN COLOR SET
This is the code corresponding to the preoperative assessment of the patient's skin color upon arrival to the operating room. If entered, this information will appear on the Nurse Intraoperative Report.

.09 DATE OF OPERATION DATE/TIME
This is the date that the case was performed. The date of operation must be entered for all cases.

.11 TRANS TO OR BY POINTER
This is the method or device used to deliver the patient to the operating room. This field is optional, but may be useful for documentation of the ccase.

.111 OR CIRC SUPPORT POINTER
This is information about the nurses with circulating role responsibilities.

.01 OR CIRC SUPPORT POINTER
This is the person with the circulating role responsibilities. This information will appear on the Nurse Intraoperative Report.

2 TIME ON DATE/TIME
This is the date and time that this person's circulating role responsibilities began. (Both date and time should be entered).

.01 TIME ON DATE/TIME
Enter the date/time that this person's circulating role responsibilities began. Note: Both the date and time must be entered for this field.

1 TIME OFF DATE/TIME
This is the date and time that the circulating role responsibilities ended. Times entered without a date will be converted to the date of the operation at that time.

2 REASON FOR RELIEF SET
This is the reason why the circulating support person was relieved, or left the operating room during this case. Although optional, this information may be important in documenting the case.

3 COMMENT WORD-PROCESSING
This includes any comments or information pertaining to this person or his or her role as circulating support for the case.

3 STATUS SET
Enter the code corresponding to the educational preparation of the registered nurse assuming circulating role responsibilities.

.112 OR SCRUB SUPPORT POINTER
This is information about the person with scrub role responsibilities.

.01 OR SCRUB SUPPORT POINTER
This is the name of the person assuming scrub role responsibilities. Although optional, this information will appear on the Nurse Intraoperative Report if entered.

1 TIME ON DATE/TIME
This is the date/time that this person's responsibilities for scrub support began. Both date and time must be entered.

.01 TIME ON DATE/TIME
This is the date/time that this person's scrub role responsibilities began. Both the date and time must be entered.

1 TIME OFF DATE/TIME
This is the date and time that this person's scrub role responsibilities ended. Times entered without a date will be converted to the date of operation at that time.

2 REASON FOR RELIEF SET
This is the reason why this person was relieved of his or her scrub role responsibilities prior to the end of this case. Although optional, this information may be useful in documentation of the case.

3 COMMENT WORD-PROCESSING
This information is used in documenting this person's scrub support responsibilities.

3 STATUS SET

This is the code corresponding to the educational preparation of the person assuming scrub role responsibilities.

.12 PREOP SHAVE BY POINTER
This is the person responsible for shaving the patient in preparation for the operative procedure (if necessary).

.13 RESTR & POSITION AIDS POINTER
This is information related to restraints and positioning aids used during this operative procedure.

.01 RESTR & POSITION AIDS POINTER
This is the restraint or positioning aid needed for securing the patient for the operative procedure. This information appears on the Nurse Intraoperative Report if entered.

1 APPLIED BY POINTER
This is the person responsible for applying the restraint or positioning aid. Although optional, this information may be useful in documenting this case. If entered, it will appear on the Nurse Intraoperative Report.

2 RESTRAINT COMMENTS FREE TEXT
This contains brief comments related to where or why a restraint or positioning aid was applied. Your answer can be up to 45 characters in length.

.14 SURGEON POINTER
This is the name of the person performing the major portion of the principal operative procedure. This field is required as part of the Operation Report.

This field may be restricted by locally determined keys so that only people with the appropriate keys can be entered.

.15 FIRST ASST POINTER
This is the name of the person assisting the surgeon during the operative procedure. The information entered here appears on the Operation Report and Nurse Intraoperative Report.

.16 SECOND ASST POINTER
This is the name of the second person assisting the surgeon during the operative procedure. If entered, this information appears on the Operation Report and Nurse Intraoperative Report.

.164 ATTEND SURG POINTER
This is the name of the attending staff surgeon responsible for this case. This information appears on the Operation Report, Nurse Intraoperative Report, and Attending Surgeon Report.

.165 ATTENDING CODE SET
This is the code corresponding to the highest level of supervision provided by the attending staff surgeon for this case. This information appears in the Operation Report, Nurse Intraoperative Report, and Attending Surgeon Report.

0 Staff alone.

1 Staff practitioner is scrubbed and present in the procedure/operating room.

2 Staff practitioner is present in the procedural/surgical suite and available for consultation.

3 Staff practitioner is not present, but immediately available to the resident, for consultation and support, via telephone or in person.

.167 PERFUSIONIST POINTER
This is the name of the person operating the cardio-pulmonary or organ perfusion apparatus. Although not required, this information may be valuable in documenting the case. If entered, it will appear on the Nurse Intraoperative Report.

.168 ASST PERFUSIONIST POINTER
This is the name of the person assisting the perfusionist. If applicable, this information may be valuable in documentation of this case.

.175 SKIN PREP AGENTS POINTER
This is the type of agent used to wash and prepare the operative site. If entered, this information appears on the Nurse Intraoperative Report and is useful in documenting the case.

.18 SKIN PREPPED BY (1) POINTER
This is the name of the person responsible for applying the agent used to wash and prepare the operative site. If entered, this information will appear on the Nurse Intraoperative Report.

.19 PREOP MOOD POINTER
This is the preoperative assessment of the patient's emotional status upon arrival to the operating room. It may be useful in the documentation of the case. If entered, this information will appear on the Nurse Intraoperative Report.

.195 PREOP CONVERSE SET
This is the preoperative assessment of the patient's demonstrated verbal responses upon arrival to the operating room. Although optional, this field may be valuable in documenting this case.

.196 PREOP CONSCIOUS POINTER
This is the preoperative assessment of the patient's level of consciousness upon arrival to the operating room. Although optional, this information may be useful in documenting the case.

.202 NURSE PRESENT TIME DATE/TIME
This is the date and time that the nurse was present in the operating room. Times entered without a date will be converted to the date of operation at that time.

.203 TIME PAT IN HOLD AREA DATE/TIME
This is the date and time that the patient arrived in the holding area. Times entered without a date will be converted to the date of operation at that time.

.204 ANES AVAIL TIME DATE/TIME
This is the date and time that the anesthetist is available to service the patient. Although optional, this information is useful for evaluating operation delays.

.205 TIME PAT IN OR DATE/TIME
This is the date and time that the patient was transported into the operation room. Times entered without a date will be converted to the date of operation at that time.

.206 SURG PRESENT TIME DATE/TIME
This is the date and time that the surgeon is available to begin the operative procedure. Although not mandatory, this information is useful for evaluating hospital delays.

.21 ANES CARE START TIME DATE/TIME

This is the date and time that the anesthesia care began. It is required as part of the anesthesia report. The definition of what constitutes the time anesthesia care begins may vary depending on local anesthesia policy.

.215 INDUCTION COMPLETE DATE/TIME
This is the date and time that the anesthetist declares the patient ready for the start of the operative procedure. Although optional, this information may be useful in management studies.

.22 TIME OPERATION BEGAN DATE/TIME
This is the date and time that the operation began. The definition of this time is usually 'knife fall', but may vary according to local surgery service protocol.

.23 TIME OPERATION ENDS DATE/TIME
This is the date and time that all operative procedures for this case are complete. This time is usually the 'dressing complete' time, but it may vary according to local Surgery service protocol. The patient record will be incomplete until this information is entered.

.232 TIME PAT OUT OR DATE/TIME
This is the date and time that the patient is taken from the operating room. Times entered without a date will be converted to the date of operation at that time. This information is very significant for operating room management studies.

.234 OR CLEAN START TIME DATE/TIME
This is the date and time when the 'end of case' or terminal cleaning began. Times entered without a date will be converted to the date of operation at that time.

.236 OR CLEAN END TIME DATE/TIME
This is the date and time when the 'end of case' or terminal cleaning ended. Times entered without a date will be converted to the date of operation at that time.

.24 ANES CARE END TIME DATE/TIME
This is the date and time that anesthesia care ends. Its definition may vary according to local anesthesia policy. Acceptable time formats include 7:45, 745, T@7:45 and JAN 1@7:45. Times entered without a date will be converted to the date of the operation at that time.

.25 BLOOD LOSS (ML) NUMERIC
This is the number of milliliters (0-100000) of blood estimated to be lost during the operative procedure (EBL). This information appears on the Nurse Intraoperative report, if entered.

.255 TOTAL URINE OUTPUT (ML) NUMERIC
This is the total number of milliliters (0-100000) of urine output during the operative procedure. If entered, this information appears on the Nurse Intraoperative Report.

.27 REPLACEMENT FLUID TYPE POINTER
This is information related to the replacement fluid given intravascularly during the operative procedure.

.01 REPLACEMENT FLUID TYPE POINTER
This is the type of replacement fluid given intravascularly during the operative procedure.

Each unique blood product should be entered separately. This field is considered optional, but is a significant element of the Nurse's Intraoperative Report. The definition of this field may vary according to local policy.

1 QTY OF FLUID (ml) NUMERIC
This is the number of milliliters of replacement fluid given to the patient intravascularly during the operative procedure.

3 SOURCE ID FREE TEXT
This is the unique identification number or code provided by the supplier of this replacement fluid. Although optional, this information may be useful in documentation of this case.

4 VA IDENT FREE TEXT
This is the unique identification characters assigned by the local blood bank for type specific blood components.

5 REPLACEMENT FLUID COMMENTS WORD-PROCESSING
These are comments related to this specific fluid type. This information will be used in documentation of the case.

.28 GENERAL COMMENTS WORD-PROCESSING
These are general comments about the operative procedure. Any information not provided for elsewhere can be entered here.

.29 NURSING CARE COMMENTS WORD-PROCESSING
These are comments on this case required for documentation on the Nurse Intraoperative Report.

.293 MONITORS POINTER
This is information related to invasive or non-invasive monitors used during this case.

.01 MONITORS POINTER
This is the physiologic monitor used during this case. More than one monitor may be entered. The information entered appears as part of the anesthesia record.

1 TIME INSTALLED DATE/TIME
This is the time that the monitor was applied to the patient. Times entered without a date will be converted to the date of operation at that time.

2 TIME REMOVED DATE/TIME
This is the date and time that the monitor was removed from the patient. Times entered without a date will be converted to the date of operation at that time.

3 APPLIED BY POINTER
This is the name of the person responsible for applying the monitor to the patient. Although optional, this information may be useful in documentation for this case.

.31 PRINC ANESTHETIST POINTER
This is the name of the principal anesthesiologist or CRNA (or surgeon, if local anesthesia). This information is extremely important for the Anesthesia Report.

.32 RELIEF ANESTHETIST POINTER
This is the name of the anesthetist relieving the principal anesthetist, if applicable. If entered, this information appears on the Anesthesia Report.

.33 ASST ANESTHETIST POINTER
This is the name of the person assisting the principal anesthetist. If entered, this information appears on the Anesthesia Report.

.34 ANESTHESIOLOGIST SUPVR POINTER

This is the name of anesthesia supervisor. He or she may be the same person entered in the 'PRINC ANESTHETIST' or 'ASST ANESTHETIST' fields. This information is required if the principal anesthetist is in a training status, or CRNA.

.345 ANES SUPERVISE CODE POINTER
This is the code corresponding to the highest level of supervision of the anesthesiology staff supervisor. This information appears on the Anesthesia Report.

.36 MIN INTRAOP TEMPERATURE (C) NUMERIC
This is the lowest temperature of the patient during the operative procedure. If entered, this information will appear on the Nurse Intraoperative Report.

.37 ANESTHESIA TECHNIQUE SET
This is information about the anesthesia technique used during this case.

.01 ANESTHESIA TECHNIQUE SET
This is the anesthesia technique used during this case corresponding to the American Board of Anesthesiologists universal list of anesthesia techniques (except for LOCAL technique which is to be used for anesthesia administered by non-anesthesia personnel). If entered, this information will appear on various anesthesia reports.

.05 PRINCIPAL TECH SET
This indicates whether this technique is the principal technique for this procedure. If this is the only technique used, 'YES' must be entered at this prompt.

2 PATIENT STATUS SET
This indicates the status of the patient while anesthetized.

3 APPROACH SET
This is the code corresponding to the approach technique used for endotracheal intubation. This information is not required, but may be useful for documentation.

4 ROUTE SET
This is the code corresponding to the route of the endotracheal tube to the trachea. This information is not required, but may be useful for documentation.

5 LARYNGOSCOPE TYPE SET

This is the code corresponding to the type of scope or laryngoscope blade used to facilitate endotracheal intubation. Although not required, it may be useful for documentation.

6 LARYNGOSCOPE SIZE NUMERIC
This is the size of the laryngoscope used to facilitate endotracheal intubation. This information is not required, but may be useful for documentation.

7 STYLET USED (Y/N) SET
This indicates whether a stylet was used to shape the endotracheal tube during intubation. This information is optional, but may be useful in documentation of this case.

8 LIDOCAINE TOPICAL SET
This indicates whether topical lidocaine is utilized to facilitate endotracheal intubation. This information is not required, but may be useful for documentation.

9 LIDOCAINE IV SET
This indicates whether intravenous lidocaine is administered prior to the endotracheal intubation. This information is not required, but may be useful for documentation.

10 TUBE TYPE SET
This is the code corresponding to the type of endotracheal tube used during the major portion of the procedure. This information is not required, but may be useful for documentation.

11 TUBE SIZE NUMERIC
This is the size of the endotracheal tube. This information is not required, but may be useful for documentation.

12 TRAUMA SET
This is the code corresponding to trauma resulting from the endotracheal intubation process. This information is necessary to properly document airway management problems for Risk Assessment.

13 BITE BLOCK (Y/N) SET
This indicates if a bite block is used to protect the endotracheal tube. This information is not required, but may be useful for documentation.

14 TUBE LUBRICATION SET
This indicates whether lubrication was used with the endotracheal tube. Although not required, this information may be useful for documentation.

15 TAPED AT LENGTH NUMERIC
This is the length of the endotracheal tube at the external reference point. This information is not required, but may be useful for documentation of this case.

16 BREATH SOUNDS OK BILAT SET
This indicates whether breath sounds are audible and equal bilaterally. This information is not required, but may be useful for documentation.

17 HEAT, MOISTURE EXCHANGER SET
This indicates whether a passive heat and moisture exchanger is used in the breathing circuit. This information is not required, but may be useful for documentation and review.

18 BACT. FILTER IN CIRCUIT SET
This indicates whether a bacterial filter is used in the breathing circuit. This information is not required, but may be useful for documentation.

19 END VENT. T.V. NUMERIC
This is the anesthesia ventilator tidal volume setting at the end of the case.

20 END VENT. RATE NUMERIC
This is the anesthesia ventilator rate setting at the end of the operative procedure.

21 EXTUBATED IN SET
This is the code corresponding to the location wherein the endotracheal tube is removed. This information is not required, but may be useful for documentation, review or concurrent monitoring.

22 REINTUBATED W/I 8 HRS. SET
This indicates whether the patient required reintubation within 8 hours for ventilatory insufficiency or airway obstruction. Do not include intubation for a following surgical procedure.

23 PREOXYGENATION SET
This is used to document the process of preoxygenation prior to induction of anesthesia.

24 ANESTHESIA AGENTS POINTER
This is information related to the anesthesia agents used for this technique.

.01 ANESTHESIA AGENTS POINTER
More than one anesthesia agent may be entered for each technique.

The ANESTHESIA AGENT field uses entries from your local DRUG file. Prior to using the Surgery package, drugs that will be used as anesthesia agents must be flagged (using the Chief's Menu) by your package coordinator. If you are having problems entering an agent, it is likely that the drug you are choosing has not been flagged.

1 DOSE (mg) NUMERIC
This is the end total dose (in mgs) for nonvolatile agents.

25 CONTINUOUS SET
This indicates whether a catheter is placed for continuous or intermittent administration of a drug for spinal or epidural anesthesia.

26 BARICITY SET
This is the code corresponding to the baricity of the anesthesia drug fluid vehicle in relationship to the spinal fluid.

27 PUNCTURE SITE SET
This is the code corresponding to the spinal or epidural needle puncture site. This information is not required, but may be useful for documentation and review.

28 SPINAL APPROACH SET
This is the code corresponding to the approach of the placement of the spinal or epidural needle. This information is not required, but may be useful for documentation and review.

29 NEEDLE SIZE SET

This is the code corresponding to the needle size used for the spinal or epidural technique. This information is not required, but may be useful for documentation and review.

30 EPIDURAL METHOD SET
This is the code corresponding to the method used to determine the placement of the epidural needle. This information is not required, but may be useful for documentation and review.

31 MULTIPLE ATTEMPTS SET
This indicates whether more than one skin puncture was required to achieve proper placement of the needle.

32 TEST DOSE POINTER
This is information related to the test dose of the anesthesia agent.

.01 TEST DOSE POINTER
This is the name of the drug used for the epidural test dose.

1 DOSE (mg) NUMERIC
This is the number of milligrams used of the test drug.

33 TEST DOSE VOL (ml) NUMERIC
This is the volume (mls.) of the test dose fluid vehicle.

34 DURAL PUNCTURE SET
This indicates whether dural puncture is recognized during the epidural needle or catheter placement. This information is not required.

35 CATHETER REMOVED BY POINTER
This is the name of the person removing the continuous catheter from the puncture site. This information is not required, but may be useful for documentation and review.

36 ADMINISTRATION METHOD SET
This is the code corresponding to the method of administration of the anesthetic agent. This information is not required.

37 PURPOSE SET
This is the code corresponding to the reason for using a regional technique. This information is not required, but may be useful for documentation and review.

38 BLOCK SITE POINTER
This is information about the block site.

.01 BLOCK SITE POINTER
This is the name or SNOMED code of the site of the anesthetic regional block. This information is not required, but may be useful for documentation and review.

1 NEEDLE LENGTH, CM NUMERIC
This is the length of the needle (in cms.) used for the administration of the agent for regional block.

2 NEEDLE GAUGE NUMERIC
This is the gauge size of the needle used for administration of the agent for regional block.

39 EXTUBATED BY POINTER
This is the name of the person responsible for removing the endotracheal tube. Although optional, this information may be useful for documentation.

40 ANESTHESIA COMMENTS WORD-PROCESSING
These are comments related to anesthesia care for this case.

41 MONITORED ANES CARE ?(Y/N) SET
This indicates whether the anesthesia personnel monitored this patient without anesthesia. This information is not required, but may be useful for documentation and review.

42 INTUBATED ? (Y/N) SET
This indicates whether an endotracheal tube is placed.

43 LEVEL SET
This is the code corresponding to the neurodermatome anesthesia sensory level.

44 DATE/TIME CATHETER REMOVED DATE/TIME
This is the date/time that the continuous regional block catheter was removed. Times entered without a date will be converted to the date of the operation at that time.

.375 MEDICATIONS POINTER

This is information about medication for this case.

.01 MEDICATIONS POINTER
This is the name of the medication (generic or proprietary). More than one medication may be entered for each case.

1 TIME ADM DATE/TIME
This is information related to the administration of the medication.

.01 TIME ADM DATE/TIME
This is the date and time that this medication was administered.

1 DOSE FREE TEXT
This is the dose of the medication given at this time. Although optional, this information may be useful in documentation of this case.

2 ORDERED BY POINTER
This is the name of the person ordering this dose of medication. This information is optional, but may be useful in documentation.

3 ADMIN BY POINTER
This is the name of the person administering this dose of the medication. This information is optional, but may be useful for documentation of the case.

4 ROUTE SET
This is the code corresponding to the route of administration of the medication.

5 MEDICATION COMMENTS FREE TEXT
These are comments pertaining to the administration of the medication at this time.

.39 IRRIGATION POINTER
This is information related to the irrigation solution.

.01 IRRIGATION POINTER
This is the type of solution used for irrigation during the operative procedure. If entered, this information appears on the Nurse Intraoperative Report.

1 TIME DATE/TIME

This is information related to the time that the irrigation solution was utilized.

.01 TIME DATE/TIME
This is the date and time that the irrigation solution was utilized. This information is optional, but may be useful for documentation of this case.

1 AMOUNT USED NUMERIC
This is the total amount of irrigation solution used in the operative site.

2 PROVIDER POINTER
This is the name of the person responsible for the irrigation solution. Although this information is optional, it may be useful for documentation of this case.

.42 OTHER PROCEDURES FREE TEXT
This is information related to procedures performed in addition to the principal procedure.

.01 OTHER PROCEDURE FREE TEXT
This is the name of a procedure performed in addition to the principal procedure.

1.5 PROCEDURE CODE COMMENTS WORD-PROCESSING
These are comments related to this procedure.

2 COMPLETED SET
This indicates whether this procedure was completed.

3 OTHER PROCEDURE CPT CODE POINTER
This is the Current Procedural Terminology (CPT) code corresponding to this operative procedure. A CPT modifier on the CPT code may be included by appending the modifier to the CPT code separated by a hyphen in the format "XXXXX-YY" where "XXXXX" is the five character CPT code and "YY" is the two character CPT modifier.

4 OTHER PROCEDURE CPT MODIFIER POINTER

.01 OTHER PROCEDURE CPT MODIFIER POINTER

This is a procedural coding modifier used to indicate that the other procedure performed has been altered by some specific circumstance but not changed in its definition or code.

.43 REQ POSTOP CARE POINTER
This is the code corresponding to the location of care after the patient leaves the operating room and/or the post-anesthesia care unit.

.44 OR SET-UP TIME NUMERIC
This is the number of minutes (0-999) necessary to prepare the operating room for the admission of the patient for the surgical procedure.

.46 OP DISPOSITION POINTER
This is the destination of the patient immediately following the surgical procedure.

.47 PROSTHESIS INSTALLED POINTER
This is information related to the prosthesis used for this operative procedure.

.01 PROSTHESIS ITEM POINTER
This is the name of the implanted prosthetic device required for this operative procedure. If entered, this information appears on the Nurse Intraoperative Report.

1 VENDOR FREE TEXT
This is the name of the manufacturer of the implanted prosthetic device.

2 MODEL FREE TEXT
This is the model of the implanted prosthetic device.

2.5 LOT/SERIAL NO FREE TEXT
This is the lot/serial number of the implanted prosthetic device.

3 *STERILE CODE FREE TEXT
This is the sterilization number of the implanted device. This field is marked for deletion.

4 *STERILE NUMBER FREE TEXT
This is the sterilization number of the implanted prosthetic device. This field is marked for deletion.

5 STERILE RESP SET

This is the code corresponding to the sterilization accountability. Although this information is optional, it may be useful in documentation of this case.

6 SIZE FREE TEXT
This is the size of the implanted prosthetic device.

7 QUANTITY NUMERIC
This is the quantity of this prosthetic device used for this operative procedure.

.48 TIME TOURNIQUET APPLIED DATE/TIME
This is information related to the application of a tourniquet.

.01 TIME TOURNIQUET APPLIED DATE/TIME
This is the date and time that the tourniquet was applied. If entered, this information will appear on the Nurse Intraoperative Report.

1 SITE APPLIED SET
This is the code corresponding to the location on the body where the tourniquet is applied.

2 TOURNIQUET APPL. BY POINTER
This is the person responsible for the application of the tourniquet cuff at this time. Although optional, this information may be useful in documentation of this case.

3 TIME TOURNIQUET REL. DATE/TIME
This is the date and time that the tourniquet was released. Times entered without a date will be converted to the date of operation at that time.

4 PRESSURE FREE TEXT
This is the amount of pressure (in TORR) applied to the cuff. This information is optional, but may be useful in documentation of the case.

.52 FINAL COUNTS VERIFY CORRECT SET
This is the code corresponding to the status of the final count at the end of the surgical procedure.

.522 VERIFIER POINTER

This is the person responsible for verifying that the final sponge, sharps, and instrument counts are correct at the end of this operative procedure.

.523 *INST CNT CORRECT SET
Enter the code corresponding to the status of the final instrument count at the end of the surgical procedure.

This field is marked for deletion.

.525 INST CNT VERF BY POINTER
This is the name of the person accountable for verification of the final instrument count.

.54 *SURGERY POSITION POINTER
This field has been asterisked for deletion 18 months from the release of version 3.0 of the **V*IST*A** Surgery package. A multiple field titled SURGERY POSITION will be used in it's place.

.55 ELECTROGROUND POSITION POINTER
This is the code corresponding to the area of placement of the dispersive electrode pad.

.56 FOLEY CATHETER SIZE NUMERIC
This is the size of the Foley catheter.

.57 FOLEY CATHETER INSERTED BY POINTER
This is the name of the person accountable for insertion of the Foley catheter. Although this information is optional, it may be useful in documentation of this case.

.61 PREOP TEMPERATURE NUMERIC
This is the most recent ward-recorded temperature of the patient prior to transport to the operating room.

.615 PREOP WEIGHT (Kg) NUMERIC
This is the most recent ward-recorded weight of the patient prior to transport to the operating room.

.62 PREOPERATIVE HEART RATE NUMERIC
This is the most recent ward-recorded heart rate of the patient prior to transport to the operating room.

.63 PREOP BLOOD PRESSURE FREE TEXT

This is the most recent ward recorded blood pressure of the patient prior to transport to the operating room. Although optional, this information may be useful for documentation of this case.

.64 PREOP RESPIRATORY RATE NUMERIC
This is the most recent ward-recorded respiratory rate of the patient prior to transport to the operating room.

.65 FINAL ANESTHESIA TEMP (C) NUMERIC
This is the temperature, in degrees centigrade, at the time of the end of anesthesia care.

.66 POSTOP PULSE NUMERIC
This is the pulse rate of the patient upon admission to the care area immediately after the surgical procedure.

.67 POSTOP BP FREE TEXT
This is the patient's blood pressure upon admission to the care area immediately after the surgical procedure. Although this information is optional, it may be useful in documentation of this case.

.68 POSTOP RESP NUMERIC
This is the respiratory rate of the patient upon admission to the care area immediately after the surgical procedure.

.69 VALID ID/CONSENT CONFIRMED BY POINTER
This is the name of the person verifying the patient's identification band, Social Security Number, surgical site/procedure, and the entry of a valid operative consent on the patient's record.

.72 OTHER PREOP DIAGNOSIS FREE TEXT
This is information related to any diagnosis in addition to the principal preoperative diagnosis.

.01 OTHER PREOP DIAGNOSIS FREE TEXT
This is the name of an additional preoperative diagnosis, not provided in the principal preoperative diagnosis.

1 *PAIRED ORGAN SET
This is the code corresponding to the side of the body related to this preoperative diagnosis, if applicable.

2 DIAGNOSIS COMMENTS WORD-PROCESSING
These are comments related to the additional preoperative diagnosis.

3 ICD DIAGNOSIS CODE POINTER
This is the ICD Diagnosis Code which corresponds with this diagnosis. Entering this field is optional, but may be valuable in documentation of this case.

.74 OTHER POSTOP DIAGS FREE TEXT
This is information related to any postoperative diagnosis in addition to the principal postoperative diagnosis.

.01 OTHER POSTOP DIAGS FREE TEXT
This is the name of a postoperative diagnosis other than the principal postoperative diagnosis.

1 *PAIRED ORGANS SET
This is the code corresponding to the side of the body related to this preoperative diagnosis, if applicable. This field is marked for deletion.

2 DIAGNOSIS COMMENTS WORD-PROCESSING
These are comments related to the additional postoperative diagnosis.

3 ICD DIAGNOSIS CODE POINTER
This is the ICD Diagnosis Code that corresponds with this postoperative diagnosis. Although optional, this information may be useful in the documentation of this case.

.75 ELECTROCAUTERY UNIT FREE TEXT
This is information identifying the electrosurgical unit utilized during the operative procedure. The information may include, but is not limited to, unit number, ground pad lot number and/or expiration date, coag setting, cut setting, blend-BI:Setting and Bipolar BP:Setting. Examples:
Electrocautery Unit: #7 HP206 COAG:50 CUT:50 BI:1
Electrocautery Unit: DAISY:18% or DAISY BP:18%
Electrocautery Unit: VL#2 EXP 3/20/91 COAG:30 CUT:20 BI:2 #2 BP:20 (VL-VALLEYLAB)

.757 THERMAL UNIT FREE TEXT
This is information related to the temperature controlling device.

.01 THERMAL UNIT FREE TEXT
This is information identifying the specific temperature controlling device.

1 TIME ON DATE/TIME
This is the date and time that the thermal unit was activated. Times entered without a date will be converted to the date of operation at that time.

2 TEMPERATURE NUMERIC
This is the temperature setting of the temperature controlling device.

3 TIME OFF DATE/TIME
This is the date and time that the thermal unit was turned off. Times entered without a date will be converted to the date of operation at that time.

.76 POSTOP SKIN INTEG POINTER
This is the code corresponding to the assessment of the patient's skin integrity after the operative procedure. If entered, this information will appear on the Nurse Intraoperative Report.

.77 POSTOP SKIN COLOR SET
This is the code corresponding to the patient's skin color after the operative procedure. If entered, this information will appear on the Nurse Intraoperative Report.

.79 PACU DISPOSITION POINTER
This is the code corresponding to the destination of the patient immediately after release from the post-anesthesia care unit.

.81 POSTOP MOOD POINTER
This is the code corresponding to the assessment of the patient's mood following the operative procedure. If entered, this information will appear on the Nurse Intraoperative Report.

.82 POSTOP CONVERS SET
This is the code corresponding to the assessment of the patient's demonstrated verbal responses at the completion of the surgical procedure.

.821 POSTOP CONSCIOUS POINTER
This is the code corresponding to the assessment of the patient's level of consciousness following the operative procedure. If entered, this information will appear on the Nurse Intraoperative Report.

.84 END PULSE NUMERIC
This is the patient's pulse rate at the end of the operative procedure.

.85 END BP FREE TEXT
This is the patient's systolic/diastolic blood pressure at the end of the operative procedure. Although optional, this information may be useful in documentation of this case.

.86 END RESP NUMERIC
This is the patient's rate of respiration at the end of the operative procedure. This information may be useful in documentation of this case.

.875 PACKING SET
This is the code corresponding to the type of packing placed during the procedure that will remain in place when the patient is discharged from the operating room.

.971 PATIENT EDUCATION/ASSESSMENT SET
This indicates whether preoperative patient education and assessment, with documentation of a care plan, were completed during the perioperative care of the patient.

.972 CONSENT SIG&WIT SET
This indicates whether there is a properly signed and witnessed operative consent present in the patient's medical record.

.973 BATH & SHAMPOO SET
This indicates if the patient's preoperatively prescribed bath and shampoo were completed.

.974 REC&XRAY READY SET
This indicates whether the patient's x-rays and records are complete.

.975 ENEMA(S) IF ORD SET
This indicates whether the administration of preoperative enema(s) were completed, if ordered.

.976 NPO AS ORD/CLIN MID SET
This indicates whether NPO orders were completed prior to the operative procedure as ordered by the surgeon.

.977 *CLERK CHN DAYS BEFORE NUMERIC
This field is not being used and is marked for deletion.

.981 *VERFIFY ID TAG SSN SET
This indicates whether the identification bracelet and social security number verification was completed, legal and correct.

This field has been marked for deletion.

.9811 CARE PLAN IN CHART SET
This indicates whether the nursing care plan is present on the patient's medical record prior to transport of the patient into the operating room.

.9812 ADDRESS PLATE SET
This indicates if the patient's address plate is present on the patient's medical record prior to transport to the operating room.

.9813 PATIENT VOIDED SET
This indicates whether the patient voided prior to being transported to the operating room.

.9814 PREOP MED&RAIL UP SET
This indicates whether preoperative medication was administered and the side rails of the bed were placed in the 'up' position.

.9815 *CLERK CHN DATE PROCEDURE NUMERIC
This field has been marked for deletion. It should not be used.

.982 PROSTHESIS REM SET
This indicates whether prosthetics (dentures, jewelry, hair pieces) have been removed prior to transport to the operating room.

.983 CIG, MATCH & VAL REM SET
This indicates whether the patient's tobacco products, matches and valuables have been removed from his or her possession prior to being transported to the operating room.

.984 VALUABLES SECURED SET
This indicates whether the patient's valuables have been secured according to hospital policy.

.985 ORAL HYGIENE SET
This indicates whether the patient's oral hygiene was completed prior to being transported to the operating room.

.986 FRESHLY SHAVED SET
This indicates whether the patient's facial hair was freshly shaved prior to being transported to the operating room.

.987 CLEAN DRESSING SET
This indicates if all appropriate wounds have had clean dressings applied prior to transport to the operating room.

.988 CLEAN HOSP CLOTH SET
This indicates whether the patient has clean hospital clothing prior to being transported to the operating room.

.989 LEVIN TUBE/CATH SET
This indicates whether a Levin tube/catheter is present prior to transport to the operating room.

.991 U/A IN 48 HRS SET
This indicates whether the patient has had a urinalysis within 48 hours prior to being transported to the operating room.

.9911 *CLERK CHN REC FOR MAJ SURG NUMERIC
This field has been marked for deletion. It should not be used.

.992 CBC IN 48 HRS SET
This indicates whether the patient has had a CBC within 48 hours prior to being transported to the operating room.

.993 BLOOD TYPE&XMATCH SET
This indicates whether the patient has had blood typing and crossmatching done.

.994 *BLEEDING & PTT TIME IN 48 HRS SET
This indicates whether the patient has had bleed and PTT time within 48 hours prior to being transported to the operating room.

This field has been marked for deletion in the next version of the Surgery package.

.995 *BUN IN 7 DAYS SET
This indicates whether the patient has had a BUN within 7 days prior to being transported to the operating room.

This field has been marked for deletion in the next version of the Surgery package.

.996 *BLOOD SUGAR IN 7 DAYS SET
This field determines whether the patient has had a blood sugar test within the last 7 days. This field has been marked for deletion in the next release of the Surgery software.

.997 *SEROLOGY REPORT SET
This field has been marked for deletion. It should not be used.

.998 CHEST XRAY IN 7 DAYS SET
This field determines whether the patient has had a chest x-ray within the last seven days.

.999 EKG IN 24 HRS SET
This field determines whether the patient has had an EKG within the last 24 hours.

1.01 REQ ANESTHESIA TECHNIQUE SET
This is the surgeon's choice of anesthesia for the proposed operative procedure. This information will appear on the Schedule of Operations.

1.02 REQ FROZ SECT SET
This indicates whether laboratory support is needed to perform frozen section diagnostic tests during the operative procedure.

1.03 REQ PREOP X-RAY FREE TEXT
These are the types of preop x-ray films and reports required for delivery to the operating room prior to the surgical procedure.

1.035 INTRAOPERATIVE X-RAYS SET
This indicates if radiology personnel is needed in the operating room for intraoperative radiologic procedures.

1.04 REQ PHOTO SET
This indicates whether Medical Media personnel need to be present in the operating room to obtain photographs during the operative procedure.

1.05 REQ BLOOD KIND FREE TEXT
This is information related to the blood product required during this operative procedure.

.01 REQ BLOOD KIND FREE TEXT

This is the blood product required during this operative procedure. More than one type of blood product may be ordered for a procedure.

1 UNITS REQ NUMERIC
This is the number of units of this blood product type estimated to be required for this procedure.

2 SCREEN, CROSSMATCH, AUTOLOGOUS SET
This indicates whether the blood product is screened, crossmatched, or autologous.

3 REASON NOT USE STD WORD-PROCESSING
This indicates why the standard unit of this blood product was not used.

1.052 REQ BLOOD AVAIL SET
This indicates whether the requested blood components are available.

1.09 WOUND CLASSIFICATION SET
This is the code corresponding to the classification of the wound in relationship to contamination and increasing risk of infection at the time of completion of the surgical procedure.

'C' CLEAN (Class I) - An uninfected operative wound in which no inflammation is encountered and the respiratory, alimentary, genital, or uninfected urinary tract is not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow nonpenetrating (blunt) trauma should be included in this category if they meet the criteria.

'CC' CLEAN/CONTAMINATED (Class II) - An operative wound in which the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx areincluded in this category, provided no evidence of infection or major break in technique is encountered.

'D' CONTAMINATED (Class III) - Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique (e.g., open cardiac massage) or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered are included in this category.

'I' INFECTED (Class IV, also called Dirty-Infected) - Old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.

1.098 DATE/TIME OR REQUEST MADE DATE/TIME
This is the date and time that the operation request was made. This information is automatically entered at the time of request. If the request date is changed, this field will be updated to reflect the new date/time requested.

1.099 SURG SCHED PERSON POINTER
This is the name of the person requesting or scheduling this operative procedure.

1.11 PAC(U) ADMIT SCORE NUMERIC
This is the objective evaluation numerical score of the patient upon admission to the post anesthesia care unit.

1.12 PAC(U) DISCH SCORE NUMERIC
This is the objective evaluation numeric score of the patient at discharge from the post anesthesia care unit.

1.13 ASA CLASS SET
This is the American Society of Anesthesiologists class. It relates to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.

1.14 INTRAOPERATIVE OCCURRENCES FREE TEXT
This is information related to any intraoperative occurrences. If there are no occurrences, leave this field blank. 'NONE' is not an acceptable answer.

.01 INTRAOPERATIVE OCCURRENCES FREE TEXT
This is the name of the intraoperative occurrence. If no occurrences exist, this field should be left blank. Do not enter 'NONE'. It will not be accepted.

.05 OUTCOME TO DATE SET
This is the code corresponding to the outcome of this intraoperative occurrence.

1 OCCURRENCE COMMENTS WORD-PROCESSING
These are comments related to this intraoperative occurrence.

2 TREATMENT INSTITUTED FREE TEXT
This is descriptive information related to the type of treatment instituted as a result of this occurrence.

3 OCCURRENCE CATEGORY POINTER
This is the name of the category in which this occurrence will be grouped. The category should be entered for all occurrences and will be used for Surgery Central Office Reporting Needs.

4 ICD DIAGNOSIS CODE POINTER
If the occurrence entered does not fit in any of the predefined categories, it must have an ICD Diagnosis code entered.

1.145 RETURNED TO SURGERY POINTER
This is information related to the patient's return to surgery within 30 days of a prior operative procedure.

.01 RETURNED TO SURGERY POINTER
This indicates the case number if the patient has been returned to surgery within 30 days.

1 REASON SET
This is the reason that the patient was returned to surgery.

2 RET TO SURGERY COMMENTS WORD-PROCESSING
These are comments about the return to surgery which may be helpful in documentation of this case.

3 RELATED/UNRELATED SET
This determines whether the return within 30 days is related to any of the operations performed in this case. If so, enter 'R' for 'RELATED'. Otherwise, enter 'U' for 'UNRELATED'.

1.15 SURGEON'S DICTATION WORD-PROCESSING
This is the Surgeon's dictated operation note.

1.16 POSTOP OCCURRENCE FREE TEXT
This is information related to postoperative occurrences.

.01 POSTOP OCCURRENCE FREE TEXT

This is the name of an occurrence encountered postoperatively. If there are no occurrences, this field should be left blank. 'NONE' will not be accepted.

.05 OUTCOME TO DATE SET
This is the code corresponding to the outcome of this postoperative occurrence.

2 DATE COMP NOTED DATE/TIME
This is the date that this postoperative occurrence was noted in the patient's record.

3 TREATMENT INSTITUTED FREE TEXT
This is descriptive information about the treatment instituted as a result of this occurrence.

4 OCCURRENCE COMMENTS WORD-PROCESSING
These are comments about this postoperative occurrence.

5 OCCURRENCE CATEGORY POINTER
This is the name of the category in which this occurrence may be grouped. It should be entered for all occurrences and will be used by Surgery Central Office for reporting needs.

6 ICD DIAGNOSIS CODE POINTER
If the occurrence entered does not fit in any of the predefined categories,
an ICD Diagnosis Code must be entered.

1.17 ADMIT PAC(U) TIME DATE/TIME
This is the date/time that the patient was admitted to the post anesthesia care unit (recovery room). Times entered without a date will be converted to the date of operation at that time.

1.18 PAC(U) DISCH TIME DATE/TIME
This is the date/time that the patient is discharged from the post anesthesia care unit (recovery room). Times entered without a date will be converted to the date of operation at that time.

1.19 POSTOP ANES NOTE DATE/TIME

This is the date and time that the postoperative note is written in the patient's chart. Times entered without a date will be converted to the date of operation at that time.

1.21 OPERATION TIME COMPUTED
This is the number of minutes between the operation start and end times.

1.22 ANESTH INDUCT TIME COMPUTED
This is the total number of minutes between the anesthesia care start and induction complete times.

1.23 ANES CARE TIME COMPUTED
This is the number of minutes between the anesthesia care start time and anesthesia care end time.

1.24 PATIENT IN OR TIME COMPUTED
This is the number of minutes the patient was in the operating room.

1.25 OR CLEAN UP TIME COMPUTED
This is the number of minutes between the OR clean up start time and OR clean up end time.

1.26 PAC(U) TIME COMPUTED
This is the number of minutes the patient spent in the PAC(U).

4 SKIN PREPPED BY (2) POINTER
This is the name of a second person performing skin preparation, if applicable. When entered, this information appears on the Nurse Intraoperative Report.

5 SKIN PREPPED BY (3) POINTER
This is the name of the third person performing the preoperative skin preparation. If entered, this information will appear on the Nurse Intraoperative Report.

6 ELECTROGROUND POSITION (2) POINTER
This is the code corresponding to the placement of the second dispersive electrode pad.

7 DRESSING CONDITION SET
This is the status of the drainage on the dressing. Although optional, this information may be useful in documentation of this case.

8 SECOND SKIN PREP AGENT POINTER

This is the name of the SECOND antimicrobial agent used to wash and prepare the operative site. Although optional, this information may be useful in documentation of the case.

9 TIME NURSE OUT OF OR DATE/TIME
This is the date and time that the circulating nurse completed duties for the operative procedure and left the operating room.

10 SCHEDULED START TIME DATE/TIME
This is the date and time that this operative procedure is scheduled to begin.

11 SCHEDULED END TIME DATE/TIME
This is the date and time that this operative procedure is scheduled to end.

12 IN OR TO ANES START COMPUTED
This is the number of minutes between the time anesthesia care began and time that the patient left the operating room.

13 ANES START TO OP START COMPUTED
This is the number of minutes between the time that anesthesia care started and time that the operation began.

14 IN OR TO OP START TIME COMPUTED
This is the time between the time the patient enters the operating room to the operation start time.

15 DATE/TIME OF DICTATION DATE/TIME
This is the date and time that dictation of the operative summary was completed.

17 CANCEL DATE DATE/TIME
This is the date and time that the operative procedure was canceled.

18 CANCEL REASON POINTER
This is the reason that this surgical case was cancelled.

20 DIAGNOSTIC/THERAPEUTIC (Y/N) SET
This indicates if the anesthesia technique is an anesthesia diagnostic/therapeutic procedure.

22 TUBES AND DRAINS FREE TEXT

This is the type and placement of tubes and drains during the operative process.

23 REFERRING PHYSICIAN FREE TEXT
This is information related to the referring physician.

.01 REFERRING PHYSICIAN FREE TEXT
This is the name of the referring physician, or medical center. Although optional, this information may be useful in documentation of this case.

1 STREET ADDRESS FREE TEXT
This is the street address of the referring physician.

2 CITY FREE TEXT
This is the city of the referring physician.

3 STATE POINTER
This is the state of the referring physician.

4 ZIP CODE FREE TEXT
This is the zip code of the referring physician.

5 PHONE NUMBER FREE TEXT
This is the referring physician's telephone number.

24 LOCK CASE SET
This indicates whether this case has been completed and locked. Locked cases can only be edited if unlocked by the Chief of Surgery or his or her designee.

25 DISCHARGED VIA POINTER
This is the code corresponding to the mode of transport used to move the patient from the care area.

26 PRINCIPAL PROCEDURE FREE TEXT
This is the name of the principal procedure for this case. All cases must have a principal procedure.

The principal procedure must be 3 to 135 characters in length. The procedure name must not contain a semicolon (;), an at-sign (@), an up- arrow (^) or control characters. If the procedure name is longer than 30 characters, it must contain at least one space in every 31 characters of length. If a

comma is being used to separate information, a space should follow the comma.

27 PRINCIPAL PROCEDURE CODE POINTER
This is the Current Procedural Terminology (CPT) code corresponding with the principal procedure. A CPT modifier on the CPT code may be included by appending the modifier to the CPT code separated by a hyphen in the format "XXXXX-YY" where "XXXXX" is the five character CPT code and "YY" is the two character CPT modifier.

28 PRIN. PROCEDURE CPT MODIFIER POINTER

.01 PRIN. PROCEDURE CPT MODIFIER POINTER
This is a procedural coding modifier used to indicate that the principal procedure performed has been altered by some specific circumstance but not changed in its definition or code.

29 *PROCEDURE COMPLETED SET
This indicates whether the principal operative procedure was completed.

This field has been marked for deletion.

30 OTHER SCRUBBED ASSISTANTS POINTER
This is information about other persons in the operating room in addition to those already listed as scrubbed.

.01 OTHER SCRUBBED ASSISTANTS POINTER
These are names of persons in the operating room other than those that are already listed as scrubbed.

1 COMMENTS WORD-PROCESSING
These are comments related to this person that may be useful in documentation of this case.

31 OTHER PERSONS IN OR FREE TEXT
This is information related to other persons, not scrubbed or otherwise identified, present in the operating room.

.01 OTHER PERSONS IN OR FREE TEXT
These are the names of other persons not scrubbed, or otherwise identified, present in the operating room.

1 TITLE/ORGANIZATION FREE TEXT
This is the title and/or organization of this person. Since your answer may be up to 60 characters, you may prefer to enter a reason for this person being in the operating room.

32 PRINCIPAL PRE-OP DIAGNOSIS FREE TEXT
This is the preoperative diagnosis for which the surgical procedure is being performed.

33 PRINCIPAL DIAGNOSIS FREE TEXT
This is the principal diagnosis for which the non-OR procedure is being performed.

34 PRINCIPAL POST-OP DIAG FREE TEXT
This is the principal postoperative diagnosis.

35 CONCURRENT CASE POINTER
This identifies that this patient has another operation occurring at the same time as this case by another surgical specialty.

36 REQUESTED NUMERIC
This indicates whether this case was requested.

37 ESTIMATED CASE LENGTH FREE TEXT
This is the amount of time estimated to perform this operative procedure. Your answer should be in the format of "HOURS:MINUTES". For example, if the procedure will last 2 and 1/2 hours, your answer would be 2:30.

38 REQUEST BLOOD AVAILABILITY SET
This determines whether blood will be requested for this surgical procedure. Enter 'YES' if blood will be requested. Otherwise, enter 'NO'.

39 DATE OF TRANSCRIPTION DATE/TIME
This is the date and time that transcription of the operative summary was completed.

40 CROSSMATCH, SCREEN, AUTOLOGOUS SET
This determines whether the requested blood will be typed and crossmatched, screened, or autologous.

41 DRESSING FREE TEXT
These are the dressing(s) used for this case. Although optional, this information may be useful in documentation of this case.

42 DELAY CAUSE POINTER
This is information related to the reason why this case did not begin at its scheduled start time.

.01 DELAY CAUSE POINTER
This is the reason why the operative procedure did not begin at the scheduled start time.

1 DELAY TIME NUMERIC
This is the number of minutes (1-600) that this case was delayed due to this cause. Although optional, this information will appear on the Report of Delayed Operations.

2 DELAY COMMENTS WORD-PROCESSING
This contains comments related to the delay cause.

43 CASE VERIFICATION SET
This indicates whether the principal operative procedure, CPT code, perioperative occurrences and diagnosis were verified by the surgeon.

44 SPONGE COUNT CORRECT (Y/N) SET
This indicates whether the final sponge count was correct. If entered, this information will appear on the Nurse Intraoperative Report.

45 SHARPS COUNT CORRECT (Y/N) SET
This indicates whether the final sharps count was correct. If entered, this information will appear on the Nurse Intraoperative Report. The type of information entered in this field is determined by local hospital policy.

46 INSTRUMENT COUNT CORRECT (Y/N) SET
This indicates whether the final instrument count was correct for this case. This information appears on the Nurse Intraoperative Report. The type of information entered in this field is determined by local hospital policy.

47 SPONGE, SHARPS, & INST COUNTER POINTER
This is the name of the person doing the final count of sponges, sharps and instruments. If entered, this information appears on the Nurse Intraoperative Report.

48 COUNT VERIFIER POINTER
This is the name of the person responsible for verifying the final sponge, sharps and instrument counts.

49 SPECIMENS WORD-PROCESSING
These are the names of specimens sent to the lab for analysis.

50 DIVISION POINTER
This is the name of the institution credited for performing this operative procedure.

51 PREOP ATTENDING CONCURRENCE SET
This field serves as a flag that the attending has concurred with the preoperative workup.

52 POSTOP ATTENDING CONCURRENCE SET
This field serves as a flag that the attending concurs with the postoperative workup.

53 NON-OPERATIVE OCCURRENCES FREE TEXT
These are occurrences that are not related to a surgical procedure. If there are not any non-operative occurrences, leave this field blank. Do not enter 'NO' or 'NONE'.

.01 NON-OPERATIVE OCCURRENCES FREE TEXT
This is a occurrence that is not related to a surgical procedure. If there are not any non-operative occurrences, this field should be left blank. Do
not enter 'NO' or 'NONE'.

1 OUTCOME TO DATE SET
This is the outcome to date of this non-operative occurrence.

2 DATE OCCURRENCE NOTED DATE/TIME
This is the date that this occurrence was noted. The time of day can be entered, but is not required.

3 TREATMENT INSTITUTED FREE TEXT
This is the type of treatment instituted as a result of this non-operative occurrence.

4 OCCURRENCE COMMENTS WORD-PROCESSING
This is information that may be helpful in documentation of the non-operative occurrence.

5 OCCURRENCE CATEGORY POINTER
This is the name of the category for which this occurrence will be grouped for Surgery Central Office reporting needs.

54 OCCURRENCE/NO PROCEDURE SET
This indicates that this case was a occurrence, not related to a surgical procedure.

55 INDICATIONS FOR OPERATIONS WORD-PROCESSING
This is a brief statement of the indications for this operative procedure. The information you enter here prints automatically as the first part of the operative summary.

56 PRE-ADMISSION TESTING SET
This indicates whether pre-admission testing was complete. It will be reflected on the Schedule of Operations for outpatients.

57 ESU COAG RANGE FREE TEXT
This is the power setting range on the Electrosurgical Unit during coagulation. This information is optional, but may be useful in documenting the case.

58 ESU CUTTING RANGE FREE TEXT
This is the power setting range on the Electrosurgical Unit during cutting. This information is optional, but may be useful in documenting the case.

59 OPERATIVE FINDINGS WORD-PROCESSING
This field contains a brief description of the operative findings which appears on the Tissue Examination Report.

60 BRIEF CLIN HISTORY WORD-PROCESSING
This field contains a brief clinical history for this patient. It will appear on the Tissue Examination Report.

61 DIAGNOSTIC RESULTS CONFIRM BY POINTER
This is the name of the person responsible for verifying that the essential diagnostic procedure requirements, as per medical center policy, are available.

62 GASTRIC OUTPUT NUMERIC
This is the gastric output during the operative procedure. It is recorded in cc's, and appears on the Nurse Intraoperative Report.

63 IV STARTED BY POINTER
This is the name of the person that started the IV for this operative procedure.

64 CULTURES WORD-PROCESSING
These are the names of cultures sent to the laboratory for examination.

65 SURGERY POSITION POINTER
This is the position in which the patient is placed for this operative procedure. This information will appear on the Nurse Intraoperative Report.

.01 SURGERY POSITION POINTER
This is the position in which the patient is placed for this operative procedure. More than one position may be entered for each case.

1 TIME PLACED DATE/TIME
This is the date/time that the patient was placed in this position. Times without a date can be entered.

66 PRIN DIAGNOSIS CODE POINTER
This is the principal ICD9 diagnosis code. It should be entered for all cases and will be used for Surgery Central Office reporting needs.

67 CANCELLATION AVOIDABLE SET
This field contains a set of codes used to flag a cancellation as being avoidable or unavoidable. It is used when determining the percentage of avoidable cancellations.

68 SCHEDULED PROCEDURE FREE TEXT
This field contains the scheduled (or original) principal procedure for this case. It will be compared to the actual procedure completed.

69 CODING VERIFIER POINTER
This is the person who last updated procedure and/or diagnosis descriptions and/or codes for this case using the Update/Verify Procedure/Diagnosis Codes [SRCODING EDIT] option. This field is updated automatically by the option when information is changed.

70 CANCELLED BY POINTER
This is the name of the person who cancelled this surgical case. This information is automatically entered when a case is cancelled.

71 TIME OUT VERIFIED SET
This field refers to the completion of a "Time Out" verification process prior to the start of the procedure. Enter YES if the "Time Out" verification process was completed prior to the start of the procedure. If entered "NO", a justification should be documented in the Nursing Care Comments.

72 IMAGING CONFIRMED SET
This field refers to the completion of the verification process for the presence of relevant imaging data to confirm that the operative site for the correct

patient are available, properly labeled and properly presented, and verified by two members of the operating team prior to the start of the procedure.

80 SPD COMMENTS WORD-PROCESSING
This field contains any information for SPD that cannot be entered elsewhere. These comments will be sent to SPD via the Surgery/CoreFLS interface.

81 DYNAMED NOTIFIED SET
This field indicates whether or not a notification has been sent to DynaMed by way of the CoreFLS interface. YES indicates at least one notification has been sent, while a null value or zero indicates that no notification has been sent. The first notification sent to DynaMed will be a NEW APPOINTMENT notification. Subsequent notifications will be for editing, canceling, or deleting notifications, as appropriate.

100 ORDER NUMBER POINTER
This is the pointer to the ORDER file (100). It will be created when a case is requested.

101 STAFF/RESIDENT SET
This determines whether the surgeon was a resident or staff. It will be used for categorizing procedures in the Annual Report of Surgical Procedures.

102 REASON FOR NO ASSESSMENT SET
This is the reason why no assessment was entered for this particular surgical case. It should be entered if any major procedure was excluded from the risk assessment module.

1 - Patient did NOT receive general, spinal, or epidural anesthesia.
2 - Number of surgical cases entered into the Surgical Risk Study exceeded 36 over an 8-day time frame.
3 - Number of TURPs or TURBTs exceeded 5 cases over an 8-day time frame.
4 - Study exclusion criteria prohibits patient entry.
6 - Surgical Clinical Nurse Reviewer was on Annual Leave.
8 - Case was a concurrent case, secondary to an assessed primary case.
9 - Number of inguinal hernias exceeded 5 cases over an 8-day time frame.

103 ANESTHETIST CATEGORY SET
This field holds the category of the principal anesthetist, which is used on the Anesthesia AMIS report to enumerate the number of anesthetics administered by each category.

118 NON-OR PROCEDURE SET
This field is a flag signifying this case is a non-OR surgical procedure.

119 NON-OR LOCATION POINTER
This is the location (file 44) where this non-OR procedure was performed.

120 DATE OF PROCEDURE DATE/TIME

This is the date that the non-OR procedure was performed. The date of procedure must be entered for all non-OR cases.

121 TIME PROCEDURE BEGAN DATE/TIME
This is the date and time that the non-OR procedure began.

122 TIME PROCEDURE ENDED DATE/TIME
This is the date and time that all the procedures for this non-OR case are complete.

123 PROVIDER POINTER
This is the person who performs the major portion of the principal non-OR procedure. This field is required for several reports.

124 ATTEND PROVIDER POINTER
This is the name of the attending staff provider responsible for this case. This information appears on several reports.

125 MEDICAL SPECIALTY POINTER
This is the medical specialty credited for doing this non-OR procedure. Many reports are sorted by the medical specialty. This field should be entered prior to completion of this non-OR procedure.

126 PROCEDURE OCCURRENCE FREE TEXT
This is an occurrence that is related to a non-O.R. procedure. If there are not any non-O.R. procedure occurrences, this field should be left blank. Do not enter 'NO' or 'NONE'.

.01 PROCEDURE OCCURRENCE FREE TEXT
This is an occurrence that is related to a non-O.R. procedure. If there are not any non-O.R. procedure occurrences, this field should be left blank. Do not enter 'NO' or 'NONE'.

1 OUTCOME TO DATE SET
This is the outcome to date of this non-O.R. procedure occurrence.

2 DATE OCCURRENCE NOTED DATE/TIME
This is the date that this occurrence was noted. The time of day can be entered, but is not required.

3 TREATMENT INSTITUTED FREE TEXT
This is the type of treatment instituted as a result of this non-O.R. procedure occurrence.

4 OCCURRENCE COMMENTS WORD-PROCESSING
This is information that may be helpful in documentation of the non-O.R. procedure occurrence.

5 OCCURRENCE CATEGORY POINTER
This is the name of the category for which this occurrence will be grouped for Surgery Central Office reporting needs.

127 SEQUENTIAL COMPRESSION DEVICE SET
This determines whether a sequential compression device was used.

128 LASER TYPE FREE TEXT
This determines whether a laser was used during this procedure. If applicable, enter the type of laser used during this surgical procedure.

200 OPERATIONS THIS ADMISSION NUMERIC
This is the total number of surgical procedures, prior to the index or principal operation, which required the patient to be taken to the operating room for any type of surgical intervention during this hospital admission. Include all procedures whether or not they are part of the inclusion/exclusion criteria.

201 REDO PROCEDURE SET
This determines whether the principal operative procedure was a reoperation in the same anatomic location for the same purpose as the first operation regardless of the length of time from the original surgical date.

202 CURRENT SMOKER SET
For non-cardiac assessment, did the patient smoke cigarettes in the year prior to admission for surgery?

For cardiac assessment, did the patient smoke tobacco in any form in the 2 weeks prior to surgery?

202.1 PACK/YEARS NUMERIC
If the patient has ever been a smoker, enter the total number of pack/years of smoking for this patient. The number of pack/years is determined by multiplying the number of packs of cigarettes smoked per day by the number of years the patient has smoked. If the patient has never been a smoker, enter "0". If the smoking history for this patient cannot be determined, enter "NS". The possible range for number of pack/years is 0 to 200.

203 HISTORY OF COPD SET
This determines whether the patient has chronic obstructive pulmonary disease (COPD) resulting in functional disability, and/or hospitalization, and/or requiring chronic bronchodilator therapy, and/or an FEV1 of less than 75% of predicted.

For non-cardiac assessment, do not include patients with acute asthma, an acute and chronic inflammatory disease of the airways resulting in bronchospasm.

204 VENTILATOR DEPENDENT SET

This determines whether the patient required ventilator assisted respirations at any time within 48 hours prior to surgery.

205 PRIOR MI SET
This determines whether the patient has a history of non-Q wave or Q wave myocardial infarction as diagnosed in his or her medical records. Select the appropriate category.

206 VASCULAR (Y/N) SET
This determines whether the patient has any vascular problems.

207 CONGESTIVE HEART FAILURE SET
This determines whether the patient has a history of congestive heart failure (CHF). CHF is defined as the inability of the heart to pump sufficient quantity of blood to meet the metabolic needs of the body or can do so only at increased ventricular filling pressure. Common manifestations are:

1) abnormal limitation in exercise tolerance due to dyspnea or fatigue
2) orthopnea (dyspnea on lying supine)
3) paroxysmal nocturnal dyspnea (PND - awakening from sleep with dyspnea which is relieved by assuming an upright position)
4) increased jugular venous pressure
5) pulmonary rales on physical examination
6) cardiomegaly
7) pulmonary vascular engorgement

The New York Heart Association functional classification is commonly used as a subjective assessment of the severity of congestive heart failure. If none or only one of the above manifestations has been present, or congestive heart failure is not mentioned as an active problem in the 30 days preceding surgery, code as 'I'.

I - cardiac disease, no symptoms of abnormal fatigue or dyspnea

If two or more of the above manifestations are present, or if congestive heart failure is mentioned as an active problem in the 30 days preceding surgery, code as 'II', 'III', or 'IV'.

II - slight limitation of physical activity by fatigue or dyspnea
III - marked limitation of physical activity by fatigue or dyspnea
IV - symptoms at rest and/or inability to carry out any physical activity without symptoms of fatigue or dyspnea

208 HYPERTENSION REQUIRING MEDS SET

This determines whether the patient has a history of a persistent elevation of systolic blood pressure > 140 mm Hg and a diastolic blood pressure > 90 mm Hg requiring an antihypertensive treatment (e.g diuretics, beta blockers, or ACE inhibitors).

209 CARDIOMEGALY SET
This determines whether the patient has generalized cardiac enlargement on a chest x-ray within 30 days preceding surgery.

210 CENTRAL NERVOUS SYSTEM (Y/N) SET
This determines whether the patient has a history of illness related to the central nervous system (CNS).

211 CURRENTLY ON DIALYSIS SET
This determines whether the patient is currently on dialysis. If there is chronic renal failure requiring periodic peritoneal or hemodialysis, enter 'YES'.

212 ASCITES SET
This determines if the patient has the presence of fluid accumulation in the peritoneal cavity noted on physical examination, abdominal ultrasound, or abdominal CT.

213 ESOPHAGEAL VARICES SET
This determines whether the patient has esophageal varices. Esophageal varices are engorged collateral veins in the esophagus which bypass a scarred liver to carry portal blood to the superior vena cava. A sustained increase in portal pressure results in esophageal varices which are most frequently demonstrated by direct visualization at esophagoscopy.

214 PGY OF PRIMARY SURGEON NUMERIC
This is the number of surgical residency (post graduate) years of the primary surgeon (1-10). Enter 0 if the primary surgeon is a staff surgeon and not a resident.

215 WEIGHT LOSS > 10% SET

This determines if the patient has experienced a greater than 10% weight decrease in body weight in the immediate six month interval preceding surgery as manifested by serial weights in the chart, as reported by the patient, or as evidenced by change in clothing size or severe cachexia. Exclude patients who have intentionally lost weight as part of a weight reduction program.

216 BLEEDING DISORDERS SET

This determines whether the patient has a history of a bleeding disorders. Bleeding disorders are defined as conditions resulting in excessive bleeding requiring hospitalization due to a deficiency of blood clotting elements (e.g., vitamin K deficiency, hemophilia, thrombocytopenia, chronic anticoagulation therapy that has not been discontinued or reversed prior to surgery.

217 TRANSFUSION > 4 RBC UNITS SET

This determines whether the patient has had a preoperative loss of blood necessitating a minimum of 4 units of whole blood/packed red cells transfused during the present admission, including in the emergency room.

218 OPEN WOUND SET

This determines whether the patient exhibits evidence of localized wound infection or an open wound which communicates to the air by direct exposure, with or without cellulitis or purulent exudate.

218.1 PREOPERATIVE SEPSIS SET

Enter YES if the patient had an episode of sepsis in the 48 hours prior to surgery. Sepsis is a clinical diagnosis typically characterized by fever and elevated white blood cell count in the peripheral blood, sometimes accompanied by hypotension, shock, and/or bacteremia. Common sources of sepsis are the urinary tract, intra-abdominal infection, skin infection, and pneumonia. Patients with sepsis will have been treated with broad-spectrum antibiotics and continue on some antibiotic coverage up to the time of surgery.

219 PREOPERATIVE HEMOGLOBIN FREE TEXT

This is the result of the preoperative hemoglobin test. Data input must be 1 to 7 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

220 PREVIOUS PTCA PROCEDURE SET

This determines whether the patient has had a previous Percutaneous Transluminal Coronary Artery (PTCA) angioplasty. Enter 'YES' if the patient has ever had this procedure performed. This does not include valvuloplasty procedures.

221 PREOPERATIVE CPK NUMERIC

This is the result of the preoperative creatinine phosphokinase (CPK) test.

222 PREOPERATIVE MB BAND NUMERIC
This is the value of the preoperative methyline blue (MB) band. Your answer must be between 0 and 50.

223 PREOPERATIVE SERUM CREATININE FREE TEXT
This is the serum creatinine result (mg/dl) most closely preceding surgery. Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

224 PREOPERATIVE BUN FREE TEXT
This is the result of the preoperative Blood Urea Nitrogen (BUN) test. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

225 PREOPERATIVE SERUM ALBUMIN FREE TEXT
This is the result of the preoperative serum albumin test. Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

226 PREOPERATIVE SGPT NUMERIC
This is the result of the preoperative serum glutamic pyruvic transaminase (SGPT) test.

227 PREOPERATIVE SGOT FREE TEXT
This is the result of the preoperative serum glutamic oxaloacetic (SGOT) test. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

228 PREOPERATIVE TOTAL BILIRUBIN FREE TEXT
This is the result of the preoperative total bilirubin test. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

229 PREOPERATIVE ALK PHOSPHATASE FREE TEXT

This is the result of the preoperative alkaline phosphatase test. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

230 PREOPERATIVE WBC FREE TEXT
This is the result of the preoperative white blood count (WBC). Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

231 PREOPERATIVE PLATELET COUNT FREE TEXT
This is the result of the preoperative platelet count. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

232 PREOPERATIVE PT FREE TEXT
This is the result of the preoperative prothombin time (PT). Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

233 PREOPERATIVE PTT FREE TEXT
This is the result of the preoperative partial thromboplastin time (PTT). Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

234 PREOPERATIVE HEMATOCRIT FREE TEXT
This is the result of the preoperative hematocrit test. Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

235 ASSESSMENT STATUS SET
This is the current status of the surgery risk assessment. When creating a new assessment, the status will automatically be entered as 'INCOMPLETE'. Upon completion of the assessment, this field will be updated to 'COMPLETED'. After the assessment is transmitted, this field will be automatically updated to 'TRANSMITTED'.

236 HEIGHT NUMERIC
This is the height of the patient. The measurement should be entered in inches (48 to 86) or centimeters (122 to 218). If you are entering the patient's height in centimeters, enter 'C' after the number of centimeters.

Your answer should be in one of the following two formats.

68 (representing inches)
173C (representing centimeters)

237 WEIGHT NUMERIC
Enter the patient's most recent weight in pounds (50 to 400) or kilograms (23 to 182). If you are entering the patient's weight in kilograms, enter 'K' after the number of kilograms.

Your answer should be in one of the following formats.

178 (weight in pounds)
80K (weight in Kilograms)

238 DNR STATUS SET
This determines the patient's 'Do Not Resuscitate' status. If the patient has had a DNR order written in the physician's order sheet of the patient's hart and it has been signed by an attending physician (this is the only ondition under which a DNR order is "official" in VHA) in the 30 days prior to this surgery, enter YES. If the DNR order was rescinded immediately prior to surgery in order to operate on the patient, still enter "YES". Answer "NO" if DNR discussions are documented in the progress note, but no official DNR order has been written in the physician order sheet or if official order has not been signed by the attending physician.

239 PREOPERATIVE HEMOGLOBIN, DATE DATE/TIME
This is the date that the preoperative hemoglobin test was performed.

240 FUNCTIONAL HEALTH STATUS SET
For non-cardiac assessment, this is the patient's functional health status on admission, reflecting the patient's pre-hospitalization functional status. If the patient is a long-term resident of the VA, this is the functional health status immediately prior to the illness or event that precipitated this operation.

For a cardiac assessment, enter the appropriate term to indicate the level of self care demonstrated by this patient that summarizes his or her status over the two weeks preceding surgery.

1. The patient is independent in activities of daily living. He or she does not require assistance of nursing care, equipment or devices. This would include a person who is able to function independently with a prosthesis.
2. The patient is partially dependent. He or she requires the use of equipment or devices coupled with assistance from another person to perform some activities of daily living. Any patient coming from a nursing home setting who is not totally dependent would fall into this category. Also, any patient who requires kidney dialysis, or requires chronic oxygen therapy, yet maintains independent functions would be grouped in this category.
3. The patient is totally dependent and cannot perform ANY activities of daily living on their own. This would include a patient in an ICU/floor who is totally dependent upon nursing care, or a dependent nursing home patient.

All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADL's just like the non-psychiatric patient. For instance, if a patient with schizophrenia is able to care for him/herself without the assistance of nursing care, he/she is considered independent.

241 PULMONARY (Y/N) SET
This determines whether the patient has a history of pulmonary illnesses.

242 CARDIAC (Y/N) SET
This determines whether the patient has a history of cardiac illnesses.

243 RENAL (Y/N) SET
This determines whether the patient has a history of renal illnesses.

244 HEPATOBILIARY (Y/N) SET
This determines whether the patient has a history of hepatobiliary illnesses.

245 NUTRITIONAL/IMMUNE/OTHER SET
This determines whether the patient has a history of illness related to nutrition, immune deficiencies or other general deficiencies.

246 ETOH > 2 DRINKS/DAY SET
This determines whether the patient admits to drinking greater than 2 ounces of hard liquor, or greater than 2 beers per day within the two weeks prior to admission.

247 LENGTH OF POST-OP STAY NUMERIC

This is the total number of days that the patient stayed in the acute care services of the medical center. The number of days should include the day after surgery and the date of discharge or transfer to intermediate or chronic care facility.

Enter NA if LENGTH OF POST-OP STAY is not applicable.

248 SUPERFICIAL POSTOP INFECTION SET
This determines whether the patient has a superficial postoperative wound infection.

[CDC Definition] Superficial surgical wound infections are infections that occur at an incision site within 30 days after surgery and involve skin, subcutaneous tissues, or muscle located above the fascial layer AND any of the following:
a. Purulent drainage from incision or drain located above the fascial layer.
b. Organism isolated from culture of fluid from wound closed primarily.
c. Surgeon deliberately opens wound, unless wound is culture-negative.
d. Surgeon's or attending physician's diagnosis of infection.

249 DEEP POSTOP INFECTION SET
This determines whether the patient has a deep postoperative wound infection.

[CDC Definition] Deep surgical wound infection occurs at an operative site within 30 days after surgery if no implant is left in place or within 1 year if implant is in place and infection appears related to surgery and infection involves tissues or spaces at or beneath fascial layer AND any of the following:
a. Purulent drainage from drain placed beneath fascial layer.
b. Wound spontaneously dehisces or is deliberately opened by surgeon when patient has fever (>38 degrees C) and/or localized pain or tenderness, unless wound is culture negative.
c. An abscess or other evidence of infection seen on direct examination, during surgery, or by histopathological examination.
d. Surgeon's diagnosis of infection.

250 SYSTEMIC SEPSIS SET
This determines whether the patient is noted to be acutely ill, usually febrile, resulting from the presence of microorganisms or their poisonous products in the blood stream. Enter 'YES' if one or more blood cultures are positive and antibiotic therapy was instituted.

251 PNEUMONIA SET

This determines whether the patient has postoperative pneumonia.

[CDC Definition] Pneumonia must meet one of the following TWO criteria:

1. Rales or dullness to percussion on physical examination of chest AND any of the following:
   a. New onset of purulent sputum or change in character of sputum.
   b. Organism isolate from blood culture.
   c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy.
2. Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion AND any of the following:
   a. New onset of purulent sputum or change in character of sputum.
   b. Organism isolate from the blood.
   c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy.
   d. Isolation of virus or detection of viral antigen in respiratory secretions.
   e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen.
   f. Histopathologic evidence of pneumonia.

252 PULMONARY EMBOLISM SET

This determines whether the patient has a postoperative pulmonary embolism. A pulmonary embolism is defined as a lodgment of a blood clot in the pulmonary artery with subsequent obstruction of the blood supply to the lung parenchyma (usually from the deep leg veins). Enter 'YES' if the patient has a V-Q scan interpreted as a high probability of pulmonary embolism or a positive pulmonary arteriogram. The diagnosis should be confirmed by the surgeon and heparin therapy should be initiated unless prevented by the patient's death.

253 OTHER RESPIRATORY OCCURRENCE POINTER

This is the ICD Diagnosis code related to a postoperative respiratory occurrence other than pneumonia, pulmonary embolism, or failure to breathe without a respirator.

254 ACUTE RENAL FAILURE SET

This determines whether the patient has acute renal failure requiring dialysis.

If entering a non-cardiac assessment, acute renal failure is defined as a patient who did not require dialysis preoperatively, that has worsening of

renal dysfunction postoperatively requiring hemodialysis, ultrafiltration, or peritoneal dialysis.

If entering a cardiac assessment, renal failure requiring dialysis is defined as development or exacerbation of renal failure requiring the initiation of dialysis (hemodialysis, ultrafiltration, or peritoneal) after leaving the operating room during the postoperative hospitalization.

255 URINARY TRACT INFECTION SET

This determines whether the patient has a postoperative urinary tract infection.

[CDC Definition] Symptomatic urinary tract infection must meet one of the following TWO criteria:

1. One of the following: fever (>38 degrees C), urgency, frequency, dysuria, or suprapubic tenderness AND a urine culture of >100,000 colonies/ml urine with no more than two species of organisms.
2. Two of the following: fever (>38 degrees C), urgency, frequency, dysuria, or suprapubic tenderness AND any of the following:
   a. Dipstick test positive for leukocyte esterase and/or nitrate.
   b. Pyuria (>10 WBCs/cc or >3 WBC/hpf of unspun urine).
   c. Organisms seen on Gram stain of unspun urine.
   d. Two urine cultures with repeated isolation of the same uropathogen with >100 colonies/ml urine in non-voided specimen.
   e. Urine culture with <100,000 colonies/ml urine of single uropathogen in patient being treated with appropriate antimicrobial therapy.
   f. Physician's diagnosis.
   g. Physician institutes appropriate antimicrobial therapy.

256 STROKE/CVA SET

This determines whether the patient has developed any new objective neurologic deficit lasting 30 minutes or more with onset intraoperatively or occurring within 30 days following surgery.

257 POSTOP BLEEDING/TRANSFUSIONS SET

This determines whether the patient had any transfusion requiring more than 4 units (including autologous) of packed red blood cells or whole blood given from the time that he or she leaves the operating room until discharge.

258 POSTOP MYOCARDIAL INFARCTION SET

This determines whether the patient has had a myocardial infarction occur during surgery or within 30 days following surgery manifested by new Q waves on EKG.

259 PULMONARY EDEMA SET
This determines whether the patient has developed postoperative distress requiring treatment and diagnosis of CHF or pulmonary edema or Adult Respiratory Distress Syndrome.

260 DATE TRANSMITTED DATE/TIME
This is the date (or date/time) that this surgery risk assessment was transmitted.

260.1 DATE OF LAST TRANSMISSION DATE/TIME
This is the date of the retransmission if this risk assessment has been retransmitted to the national database. An assessment can be updated and retransmitted within 14 days of the original transmission date. If there was no retransmission of this assessment, this is the date of the original transmission.

261 GRAFT/PROSTHESIS/FLAP FAILURE SET
This determines whether there was mechanical failure of an extracardiac vascular graft or prosthesis including myocutaneous flaps and skin grafts requiring return to the operating room or a balloon angioplasty.

262 RETURN TO OR WITHIN 30 DAYS SET
This determines whether the patient was returned to the operating room within 30 days of the index procedure. The index procedure is the procedure for which this assessment was created. Returns to the operating room include all surgical procedures that required the patient to be taken to the surgical operating room for intervention of any kind. The number of trips the patient made to the operating room in the 30 days after the index surgical procedure should be noted in the assessment.

263 DVT/THROMBOPHLEBITIS SET
This determines whether the patient has the formation, development or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. This diagnosis is made by the surgeon and may include confirmation by a venogram. The patient must be treated with heparin and/or coumadin or wafarin, and/or placement of a vena cava filter or clipping of the vena cava.

264 CEREBRAL VASCULAR DISEASE SET

This determines whether the patient has disease of the arteries to the head manifested by previous stroke (cerebral vascular accident), and/or transient ischemic attack (TIA), and/or prior surgical repair (e.g. carotid endarterectomy), and/or greater than or equal to 50% obstruction of luminal diameter documented by contrast angiography or duplex ultrasound examination.

265 PERIPHERAL VASCULAR DISEASE SET

This determines whether the patient has peripheral vascular disease. Peripheral vascular disease is defined as disease of the arteries to legs below bifurcation of aorta manifested by external claudication, and/or ischemic rest pain, and/or prior revascularization procedure(s) on vessels to legs, and/or absent or diminished pulses in legs, and/or angiographic evidence of noniatrogenic peripheral arterial obstruction greater than or equal to 50% of luminal diameter.

266 PREVIOUS OPERATION WITH CPB SET

This determines whether the patient has had prior cardiac operations requiring use of a cardio-pulmonary bypass. Enter 'YES' if the patient has ever had a cardiac procedure requiring CPB. This includes coronary artery bypass graft surgery, valve replacements or repairs, repair of atrial or ventricular septal defects, etc.

267 ANGINA SET

This determines whether the patient has angina. Angina is defined as pain or discomfort between the diaphragm and the mandible resulting from myocardial ischemia usually precipitated by exertion or emotion and relieved by rest or nitroglycerine. The Canadian Cardiovascular Society (CCS) classification is now the most commonly used method to record severity of angina. Record according to the most severe angina in the 14 days before surgery:

I Ordinary physical activity, such as walking or climbing stairs does not cause angina. Angina may occur with strenuous or rapid or prolonged exertion at work or recreation.

II There is slight limitation of ordinary activity. Angina may occur with walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals or in the cold, in the wind, or under emotional stress, or walking more than two blocks on the level, or climbing more than one flight of stairs under normal conditions at a normal pace.

III There is marked limitation of ordinary physical activity. Angina may occur after walking one or two blocks on the level or climbing one flight of stairs under normal conditions at a normal pace.

IV There is inability to carry on any physical activity without discomfort. Angina may be present at rest.

268 HEPATOMEGALY SET
This determines whether the patient has the presence of hepatomegaly. Hepatomegaly is defined as enlargement of the liver indicated usually by palpation of the lower border of the liver below the right costal margin or a liver span greater than 10 cm. Hepatomegaly may be noted in acute hepatitis, fatty infiltration, passive congestion, and early biliary obstruction. It is usually noted by the physician under the abdominal portion of the H&P.

270 PREOPERATIVE SERUM SODIUM FREE TEXT
This is the result of the preoperative serum sodium test. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

271 PREOPERATIVE POTASSIUM NUMERIC
This is the result of the preoperative potassium test.

272 DATE ASSESSMENT COMPLETED DATE/TIME
This is the date that the Assessment was completed. This field will be updated if the assessment was transmitted in error.

273 PREOPERATIVE GLUCOSE NUMERIC
This is the result of the preoperative glucose test.

274 HIGHEST SERUM SODIUM FREE TEXT
This is the highest result of a postoperative serum sodium test for the selected patient. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

275 HIGHEST POTASSIUM FREE TEXT
This is the highest result of a potassium test for the selected patient. Data input must be 1 to 3 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

276 HIGHEST GLUCOSE NUMERIC
This is the highest result of a postoperative glucose test for the patient selected.

277 HIGHEST SERUM CREATININE FREE TEXT

This is the highest postoperative serum creatinine result for the selected patient. Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

278 HIGHEST CPK FREE TEXT
This is the highest result of a postoperative CPK test for the patient selected. Data input must be 1 to 6 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

279 HIGHEST CPK-MB FREE TEXT
This is the highest result of a postoperative CP-MB Band for this patient. Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

280 HIGHEST TOTAL BILIRUBIN FREE TEXT
This is the highest postoperative total bilirubin result recorded for this patient. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

281 HIGHEST WBC FREE TEXT
This is the highest postoperative WBC for the patient selected. Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

282 LOWEST SERUM ALBUMIN NUMERIC
This is the lowest postoperative serum albumin result for the patient selected.

283 LOWEST HEMATOCRIT FREE TEXT
This is the lowest postoperative hematocrit result recorded for this patient. Data input must be 1 to 4 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

284 ASSESSMENT TYPE SET
This determines whether this surgical risk assessment is a cardiac or non-cardiac procedure.

285 ON VENTILATOR > 48 HOURS SET
This determines whether the total duration of ventilator-assisted respiration during the postoperative hospitalization was greater than or equal to 48 hours.

286 OTHER URINARY TRACT OCCURRENCE POINTER
If the patient has had a postoperative urinary tract occurrence other than acute renal failure, progressive renal insufficiency, or urinary tract infection, this field will contain the ICD Diagnosis code related to that occurrence.

A urinary tract occurrence is defined as a occurrence related to the organs and ducts participating in the secretion and elimination of urine.

287 PERIPHERAL NERVE INJURY SET
This determines whether the patient has postoperative peripheral nerve injuries. The peripheral nervous system comprises the cranial and spinal nerves from their point of exit from the CNS to their termination in peripheral structures. Peripheral nerve dysfunction may result from damage to the nerve fibers, cell body, or myelin sheath. Peripheral nerves to be excluded encompass the cervical plexus, brachial plexus, ulnar plexus, lumbar-sacral plexus (sciatic nerve), peroneal nerve, and femoral nerve.

288 PREOPERATIVE CPK, DATE DATE/TIME
This is the date that the preoperative CPK was performed.

289 PREOPERATIVE MB BAND, DATE DATE/TIME
This is the date that the preoperative MB Band was performed.

290 PREOP SERUM CREATININE, DATE DATE/TIME
This is the date that the preoperative Serum Creatinine test was performed.

291 PREOPERATIVE BUN, DATE DATE/TIME
This is the date that the preoperative BUN was performed.

292 PREOP SERUM ALBUMIN, DATE DATE/TIME
This is the date that the preoperative Serum Albumin test was performed.

293 SGPT, DATE PERFORMED DATE/TIME
This is the date that the preoperative SGPT was performed.

294 SGOT, DATE PERFORMED DATE/TIME
This is the date that the preoperative SGOT was performed.

295 PREOP TOTAL BILIRUBIN, DATE DATE/TIME
This is the date that the preoperative total bilirubin was performed.

296 PREOP ALK PHOSPHATASE, DATE DATE/TIME
This is the date that the preoperative alkaline phosphatase test was performed.

297 PREOPERATIVE WBC, DATE DATE/TIME
This is the date that the preoperative WBC test was performed.

298 PREOP PLATELET COUNT, DATE DATE/TIME
This is the date that the preoperative platelet count was performed.

299 PREOPERATIVE PT, DATE DATE/TIME
This is the date that the preoperative PT test was performed.

300 PREOPERATIVE PTT, DATE DATE/TIME
This is the date that the preoperative PTT test was performed.

301 PREOP HEMATOCRIT, DATE DATE/TIME
This is the date that the preoperative hematocrit was performed.

302 PREOPERATIVE GLUCOSE, DATE DATE/TIME
This is the date that the preoperative glucose test was performed.

303 PREOP POTASSIUM, DATE DATE/TIME
This is the date that the preoperative potassium test was performed.

304 PREOP SERUM SODIUM, DATE DATE/TIME
This is the date that the preoperative serum sodium test was performed.

305 HIGH SERUM SODIUM, DATE DATE/TIME
This is the date that the highest Serum Sodium result was recorded.

306 HIGH POTASSIUM, DATE DATE/TIME
This is the date that the highest Potassium result was recorded.

307 HIGH GLUCOSE, DATE DATE/TIME
This is the date that the highest Glucose result was recorded.

308 HIGH SERUM CREATININE, DATE DATE/TIME
This is the date that the highest Serum Creatinine result was recorded.

309 HIGH CPK, DATE DATE/TIME
This is the date that the highest CPK result was recorded.

310 HIGH CPK-MB, DATE DATE/TIME
This is the date that the highest CPK-MB Band result was recorded.

311 HIGH TOTAL BILIRUBIN, DATE DATE/TIME
This is the date that the highest Total Bilirubin was recorded.

312 HIGHEST WBC, DATE DATE/TIME
This is the date that the highest WBC was recorded.

313 LOW SERUM ALBUMIN, DATE DATE/TIME
This is the date that the lowest Serum Albumin result was recorded.

314 LOW HEMATOCRIT, DATE DATE/TIME
This is the date that the lowest Hematocrit result was recorded.

315 PREOPERATIVE PT CONTROL NUMERIC
This is the result of the preoperative PT control. Your answer must be between 9 and 15.

316 PREOPERATIVE PTT CONTROL NUMERIC
This is the preoperative PTT control result. Your answer must be between 15 and 40.

318 RESPIRATORY OCCURRENCES SET
This determines whether the patient had postoperative respiratory occurrences. A respiratory occurrence is defined as an impairment to the lungs to perform their ventilatory function. This may be due to impairment of gas exchange in the lung or obstruction of the free flow of air to the lung.

319 URINARY TRACT OCCURRENCES SET
This determines whether the patient has had postoperative urinary tract occurrences. Urinary tract occurrences are defined as difficulties related to the organs and ducts participating in the secretion and elimination of urine.

320 CNS OCCURRENCES SET
This determines whether the patient has had any postoperative central nervous system (CNS) occurrences. These occurrences are defined as difficulties related to the brain and spinal cord, with their nerves and end-organs that control voluntary acts.

321 CARDIAC OCCURRENCES SET
This determines whether the patient has had any postoperative cardiac occurrences. Cardiac occurrences are defined as difficulties encountered involving the cardiac system.

322 OTHER OCCURRENCES SET
This determines whether the patient has had postoperative occurrences, such as Graft/Prosthesis Failure or Unplanned Return to OR, not included in any of the other categories.

323 CREATE RISK ASSESSMENT SET
This determines whether a risk assessment will be created for this surgical case. If answered 'NO', the information will automatically be completed so that the information will be transmitted without any additional intervention.

324 DRUG ADDICTION SET
This determines whether this patient has a history of recreational or narcotic substance abuse. There is no time limit on this data element.

325 DYSPNEA SET
This determines whether the patient suffers from difficult, painful, or labored breathing. Dyspnea may be symptomatic of numerous disorders that interfere with adequate ventilation or perfusion of the blood with oxygen. The dyspneic patient is subjectively aware of difficulty with breathing. Select the category most appropriate based on the patient's subjective assessment and your objective assessment.

1. No Dyspnea Present
2. The Patient becomes dyspneic upon modest exertion, i.e. unable to climb one flight of stairs without shortness of breath.
3. Patient is dyspneic at rest, i.e. his or her respiratory rate is greater than 30 respirations per minute.

326 CURRENT PNEUMONIA SET
This determines whether the patient currently has pneumonia.

[CDC definition] Pneumonia must meet one of the following TWO criteria:
1. Rales or dullness to percussion on physical examination of chest AND any of the following:
   a. New onset of purulent sputum or change in character of sputum.
   b. Organism isolate from blood culture.

c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy.

2. Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion AND any of the following:
   a. New onset of purulent sputum or change in character of sputum.
   b. Organism isolate from the blood.
   c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy.
   d. Isolation of virus or detection of viral antigen in respiratory secretions.
   e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen.
   f. Histopathologic evidence of pneumonia.

327 ACTIVE HEPATITIS SET

This determines whether the patient has active hepatitis. Active Hepatitis is defined as an active inflammation of the liver evidenced by elevated liver enzymes. The most common causes are viral hepatitis documented by positive serologies (A,B, or C) and recent excessive alcohol intake, or drug induced hepatitis.

328 RENAL FAILURE SET

This determines whether the patient has been diagnosed, preoperatively, as having acute renal failure. Acute renal failure is defined as a clinical condition associated with rapid, steadily increasing azotemia (increase in BUN), with a urinary output of less than 500 cc/24 hour period, and a rising creatinine above 3 mg/dl.

329 REVASCULARIZATION/AMPUTATION SET

This determines whether the patient has a history of revascularization/amputation for atherosclerotic peripheral vascular disease. This includes any type of angioplasty or revascularization procedure for atherosclerotic PVD (e.g., toe amputations, transmetatarsal amputations, below the knee or above the knee amputations). Patients who have had an amputation for trauma would not be included here.

330 REST PAIN/GANGRENE (Y/N) SET

This determines whether the patient has rest pain or gangrene. Rest pain is a more severe form of ischemic pain due to occlusive disease which occurs at rest and is manifested as a severe, unrelenting pain aggravated by elevation and often preventing sleep. Gangrene is a marked skin discoloration and disruption indicative of death and decay of tissues in the extremities due to severe and prolonged ischemia.

331 ABSENT PERIPHERAL PULSES SET

This determines whether the patient has been diagnosed on the physical examination to have absent femoral, popliteal, or pedal pulses. If he or she has had a previous amputation, record pulses as present or absent in the remaining limb.

332 IMPAIRED SENSORIUM SET
This determines whether the patient is confused/delirious and responds to verbal and/or mild tactile stimulation, including those patients with delirium tremens.

333 COMA SET
This determines whether the patient is in a coma. Coma is defined as a patient that is unconscious, postures to painful stimuli, or is unresponsive to all stimuli.

334 HISTORY OF TIA'S SET
This determines whether the patient has a history of TIA's. This is defined as a focal neurologic abnormality of sudden onset and brief duration (less than 30 minutes) that usually reflect dysfunction in a cerebral vascular distribution. These attacks may be recurrent and, at times, may prestage a stroke.

335 CVA/RESIDUAL NEURO DEFICIT SET
This determines whether the patient has a history of a past cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor, sensory, or cognitive dysfunction. (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory)

336 CVA/NO NEURO DEFICIT SET
This determines whether the patient has a history of a past cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with neurologic deficits lasting at least 30 minutes, but no current residual neurologic dysfunction or deficit.

337 NEURO DEGENERATIVE DISEASE SET
This determines whether the patient has neuromuscular degenerative disease. It is defined as any of a number of congenital, hereditary, or acquired diseases resulting in chronic neurological deficits. Common examples of these diseases include muscular dystrophy, amyotrophic lateral sclerosis (ALS or 'Lou Gerhig's Disease'), multiple sclerosis, and poliomyelitis.

338 DISSEMINATED CANCER (Y/N) SET

This determines whether the patient has cancer that: (1) has spread to more than one site in addition to the primary site, and (2) in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Other terms describing disseminated cancer include "diffuse", "widely metastatic", and "carcinomatosis". Common sites of metastases include major organs (e.g., brain, lungs, liver, meninges, abdomen, peritoneum, pleura, bone).

338.1 CHEMOTHERAPY IN LAST 30 DAYS SET
Enter YES if the patient had any chemotherapy treatment for cancer in the 30 days prior to surgery. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphomas, leukemias, and multiple myeloma.

338.2 RADIOTHERAPY IN LAST 90 DAYS SET
Enter YES if the patient had any radiotherapy treatments for cancer in the 90 days prior to surgery.

339 STEROID USE FOR CHRONIC COND. SET
This determines whether the patient has required the administration of oral or parenteral corticosteroid medications (e.g., Prednisone, Decadron) in the month prior to admission for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include patients using inhaled corticosteroid preparations or those receiving pulsed steroids directly before surgery.

340 INTRAOP RBC UNITS TRANSFUSED NUMERIC
This is the number of packed or whole red blood cells given during the operative procedure as it appears on the anesthesia record. The amount of blood reinfused from a cell saver should also be included here. For a cell saver, every 500 cc's of fluid will equal 1 unit of packed cells. If there is less than 250 cc's of fluid, enter '0'.

341 30 DAY POSTOP STATUS SET
This is the patient's status 30 days postoperatively. Please select one of the following categories.

1. Discharged alive to home, nursing home, rehabilitation, or psychiatric facility.
2. Died in Hospital perioperatively or postoperatively.

3. Still in your VAMC facility in the ICU, on a medical-surgical floor, or undergoing rehabilitation therapy.
4. Transferred to the ICU or acute care floor of another VAMC facility from your VAMC without going home.
5. Patient was discharged home, but was readmitted to any hospital within 30 days postoperatively due to a postoperative complication as confirmed by the Chief Surgical Resident, Principle Investigator, or Chief of Surgery. If the patient was readmitted due to a postoperative complication, please enter the information in the outcome section of the assessment.

342 DATE OF DEATH DATE/TIME
If the patient has died, this is the date of death.

343 OTHER CNS OCCURRENCE POINTER
This is the ICD Diagnosis code representing any other postoperative CNS occurrence which would not be included in one of the other CNS occurrence categories.

344 OTHER CARDIAC OCCURRENCE POINTER
This is the ICD Diagnosis code corresponding to any other cardiac occurrence not included in one of the other cardiac occurrence categories.

345 ILEUS/BOWEL OBSTRUCTION SET
This determines whether the patient has prolonged ileus or bowel obstruction. Ileus is obstruction of the intestines from a variety of causes including mechanical obstruction, peritonitis, adhesions, or post surgically as a result of functional dysmotility by the bowel. Bowel obstruction is any hindrance to the passage of the intestinal contents. Prolonged ileus or obstruction is defined as persisting longer than 5 days postoperatively.

346 DIABETES SET
This determines whether the patient has diabetes. Please select one of the following answers. If you are entering a non-cardiac risk assessment, this is further defined as follows.

Diabetes Mellitus Requiring Therapy with Oral Agents or Insulin: A metabolic disorder of the pancreas whereby the individual requires daily dosages of exogenous parenteral insulin or an oral hypoglycemic agent to prevent a hyperglycemic/metabolic acidosis. Do not include the patient as a diabetic if diabetes is controlled by diet alone.

NO No diagnosis of Diabetes

ORAL A diagnosis of diabetes requiring therapy with an oral hypoglycemic agent (e.g., glyburide or glipizide) in the two weeks preceding surgery.

INSULIN A diagnosis of diabetes requiring daily insulin therapy in the two weeks preceding surgery.

347 FEV1 NUMERIC
This is the forced expiratory volume in one second from the most recent pulmonary function test prior to surgery. Enter 'NS' if there has been no pulmonary function tests in the preceding year.

348 PULMONARY RALES SET
This determines whether the patient has rales not clearing with cough and not due to pneumonic process heard within two weeks prior to surgery.

349 ACTIVE ENDOCARDITIS SET
This determines whether the patient is being treated with antibiotics for active infection on or near a cardiac valve at the time of surgery or within two weeks prior to surgery.

350 RESTING ST DEPRESSION SET
This determines whether the patient has a ST-segment depression greater than or equal to 1 mm in any lead on standard resting electrocardiogram (ECG), and/or ECG diagnosis of subendocardial ischemia, left ventricular strain, or left ventricular hypertrophy with repolarization abnormality.

351 PTCA SET
This determines the patient's PTCA status. The following answers may be selected.

1 - NONE RECENT (the patient has never had a previous coronary angioplasty, or if it was greater than 72 hours prior to surgery)

2 - 12 TO 72 HOURS (the patient has had an angioplasty within 12 to 72 hours prior to surgery)

3 - LESS THAN 12 HOURS (the patient has had an angioplasty less than 12 hours prior to surgery)

352 PRIOR HEART SURGERY SET
This determines whether the patient has had any form of previous heart surgery performed through a thoracotomy during a separate, preceding

hospitalization.

353 CURRENT DIURETIC USE SET
This determines whether the patient has used any diuretic preparation within the two weeks prior to surgery.

354 CURRENT DIGOXIN USE SET
This determines whether the patient has used a digitalis preparation (digoxin, Lanoxin, digitoxin, ect.) within the two weeks prior to surgery.

355 IV NTG WITHIN 48 HOURS SET
This determines whether the patient was administered nitroglycerin intravenously within 48 hours prior to surgery.

356 PREOPERATIVE USE OF IABP SET
This determines whether there was any use of an intra-aortic balloon pump (IABP) within the two weeks prior to surgery.

357 LVEDP NUMERIC
This determines the patient's left ventricular end-diastolic pressure measured following the 'a' wave (if present) at catheterization most closely preceding surgery.

358 AORTIC SYSTOLIC PRESSURE NUMERIC
This is the patient's aortic systolic pressure measured prior to left ventricular angiography at the catheterization most closely preceding surgery.

359 PA SYSTOLIC PRESSURE NUMERIC
This is the patient's pulmonary artery (PA) systolic pressure at the catheterization most closely preceding surgery. Enter 'NS' if no right heart catheterization performed.

360 PAW MEAN PRESSURE NUMERIC
This is the patient's mean pulmonary artery wedge (PAW) pressure or left atrial pressure measured at the catheterization most closely preceding surgery. Enter 'NS' if no right or transseptal catheterization performed.

361 LEFT MAIN STENOSIS NUMERIC
Record the most severe percent stenosis of the left main coronary artery, including its most distal portion. If there is no obstruction of the left main coronary artery, be sure to record zero.

362 CORONARIES WITH STENOSIS NUMERIC

This is the category corresponding to the number of major coronaries with stenosis greater than or equal to 50%. The categories are as follows.

0 - No stenosis in any coronary artery greater than or equal to 50% (exclude diagonals)

1 - One or more stenoses greater than or equal to 50% in the left anterior descending (does not include diagonals), or circumflex (circumflex includes the marginal branches and ramus intermedius), or the right (right includes the posterior descending even if a branch of the circumflex)

2 - Stenoses greater than or equal to 50% in the left main coronary artery, or the left anterior descending (does not include diagonals) and the right (right includes the posterior descending even if a branch of the circumflex), or the left anterior descending (does not include diagonals) and circumflex (circumflex includes the marginals and ramus intermedius), or the circumflex (circumflex includes the marginals and ramus intermedius) and the right (right includes the posterior descending even if a branch of the circumflex)

3 - Stenoses greater than or equal to 50% in the left anterior descending (does not include diagonals) and the circumflex (circumflex includes the marginals and ramus intermedius) and right (right includes the posterior descending even if a branch of the circumflex) or left main and right (right includes the posterior descending even if a branch of the circumflex)

362.1 LAD STENOSIS NUMERIC

Record the most severe percent stenosis in the proximal two-thirds of the left anterior descending coronary artery. Synonyms include LAD, AD, and anterior descending. If there is no obstruction of the LAD, be sure to record zero.

362.2 RIGHT CORONARY STENOSIS NUMERIC

Record the most severe percent stenosis in the right coronary artery. Include the proximal third of the posterior descending coronary artery. The right coronary artery initially runs in the groove between the right ventricle and right atrium; it usually gives off branches to both the right and left ventricles and the right atrium. The branches to the right atrium (sinus node artery) and the right ventricle (conus branch and acute marginal branches) are commonly ignored when describing coronary artery disease. However, the right coronary artery is the most common source for the posterior descending coronary artery, and often gives off branches to the posterior-lateral free wall of the left ventricle. These are often known as left ventricular extension

branches. If there is no obstruction of these coronary arteries, be sure to record zero.

362.3 CIRCUMFLEX STENOSIS NUMERIC

Record the most severe percent stenosis in the circumflex coronary artery, including marginal branches and ramus intermedius, considered to be of adequate size for bypass grafting. Both the anatomy and the nomenclature for describing the circumflex coronary artery can be confusing -- in part because of the marked variability from patient to patient. The true circumflex lies in the groove separating the left atrium from the left ventricle (A-V groove) for a variable distance following its origination from the left main coronary artery. Typically, it gives off one or more branches that leave the A-V groove to supply the posterior-lateral free wall of the left ventricle. These are known as marginal branches. A few patients have a branch to the posterior-lateral free wall of the left ventricle arising exactly at the bifurcation of the left main coronary artery into the left anterior descending coronary artery and the circumflex coronary artery. Strictly speaking, this vessel is neither a diagonal branch of the left anterior descending coronary artery nor a marginal branch of the circumflex coronary artery. This is often called the "ramus intermedius" or "trifurcation branch". If there is no obstruction of these coronary arteries, be sure to record zero.

363 LV CONTRACTION SCORE SET

This is the LV Contraction Grade. Left ventricular function may be assessed from the preoperative contrast ventriculogram, radionuclide angiogram, or 2D echocardiogram. (If ejection fraction is available, use the corresponding grade. Otherwise, use the grade that qualitatively reflects the left ventricular function.)

GRADE	EJECTION FRACTION RANGE	DEFINITION
I	> or = 0.55	NORMAL
II	0.45 - 0.54	MILD DYSFUNCTION
III	0.35 - 0.44	MODERATE DYSFUNCTION
IV	0.25 - 0.34	SEVERE DYSFUNCTION
V	< 0.25	VERY SEVERE DYSFUNCTION
NS	UNKNOWN	NO LV STUDY

364 ESTIMATE OF MORTALITY NUMERIC

This is the physician's (cardiologist or cardiac surgeon) subjective estimate of operative mortality based on the assessment of the total clinical picture. (To avoid bias introduced by knowledge of outcome, this must be completed preoperatively. Do not calculate from the computer program provided to you.)

364.1 ESTIMATE OF MORTALITY, DATE DATE/TIME
This is the date and time that the estimate of mortality information was collected.

365 NUMBER WITH VEIN NUMERIC
This is the number of coronary artery bypass graft (CABG) anastomoses to native coronary arteries with vein regardless of whether other procedures were performed. Do not leave this information blank. If no coronary artery bypass grafts were performed, enter '0'.

366 NUMBER WITH IMA NUMERIC
This is the number of coronary artery bypass graft (CABG) anastomoses to native coronary arteries with internal mammary arteries (IMA) regardless of whether other procedures were performed. Do not leave this field blank. If no coronary artery bypass grafts were performed, enter '0'.

367 AORTIC VALVE REPLACEMENT SET
This determines whether the patient had an aortic valve replacement performed with or without additional procedures.

368 MITRAL VALVE REPLACEMENT SET
This determines whether the patient had a mitral valve replacement performed with or without additional procedures.

369 TRICUSPID VALVE REPLACEMENT SET
This determines whether the patient had a tricuspid valve replacement performed with or without additional procedures.

370 VALVE REPAIR SET
This determines whether the patient had any reparative procedure to a native valve (annuloplasty, commissurotomy, ect.) performed with cardiopulmonary bypass with or without additional procedures.

371 LV ANEURYSMECTOMY SET
This determines whether the patient had a resection or plication of a left ventricular aneurysm with or without additional procedures.

372 GREAT VESSEL REPAIR (REQ CPB) SET

This determines whether the patient had a primary procedure to repair the aorta or other great vessels requiring left heart bypass with or without aortic valve replacement, CABG, or other procedures.

373 CARDIAC TRANSPLANT SET
This determines whether the patient had an orthotopic or heterotopic transplant performed. Heart-lung transplant or isolated lung transplant should be listed under 'OTHER'.

374 ELECTROPHYSIOLOGIC PROCEDURE SET
This determines whether any procedure was performed with cardiopulmonary bypass to correct an electrophysiologic disturbance, such as resection of bypass tract(s) for WPW or endocardial resection for ventricular tachycardia. (This does not include implantation of automatic internal cardiac defibrillator AICD.)

375 MISC. CARDIAC PROCEDURES SET
This determines whether there were any miscellaneous cardiac procedures performed.

376 ASD REPAIR SET
This determines if there was a procedure performed to repair an atrial septal defect.

377 MYXOMA RESECTION SET
This determines whether a resection of an atrial myxoma was performed.

378 MYECTOMY FOR IHSS SET
This determines whether the patient had a resection of a portion of the interventricular septum for idiopathic hypertrophic subaortic stenosis (IHSS).

379 OTHER TUMOR RESECTION SET
This determines whether the patient had a resection of any tumor other than atrial myxoma from the heart requiring cardiopulmonary bypass.

380 VSD REPAIR SET
This determines whether the patient had a procedure performed to repair a ventricular septal defect.

381 FOREIGN BODY REMOVAL SET

This determines whether a procedure was performed to remove any foreign body (e.g. bullet or catheter fragment) from the heart with the aid of cardiopulmonary bypass.

382 PERICARDIECTOMY SET
This determines whether the patient had a resection of the parietal pericardium with the aid of cardiopulmonary bypass. (NOTE: Most pericardiectomies are performed without cardiopulmonary bypass.)

383 OTHER PROCEDURES (Y/N) SET
This determines whether the patient had any other surgical procedure on the heart and/or great vessels (including AICD placement) requiring cardiopulmonary bypass.

383.1 OTHER CARDIAC PROCEDURES FREE TEXT
This is the free text description of other procedures requiring cardiopulmonary bypass that were performed on this patient at the same time as the primary cardiac procedure.

384 OPERATIVE DEATH SET
This determines whether the patient died within the 30 days following surgery regardless of cause, in or out of the hospital, and any death occurring later than 30 days as a direct result of a perioperative occurrence of surgery (e.g. mediastinitis). If operative death occurred, record the date of death.

385 PERIOPERATIVE MI SET
This determines whether the patient had a myocardial infarction occurring during surgery or within 30 days following surgery manifested by new Q-waves or widening of Q-waves by 0.02 seconds.

386 ENDOCARDITIS SET
This determines whether the patient had any postoperative intracardiac infection (usually on a valve) documented by two or more positive blood cultures with the same organism, and/or development of vegetations and valve destruction seen by echo or repeat surgery, and/or histologic evidence of infection at repeat surgery or autopsy (patients with preoperative endocarditis who have the above evidence of persistent infection should be included).

387 LOW CARDIAC OUTPUT > 6 HOURS SET
This determines whether the patient has had a postoperative cardiac index of less than 2.0 L/min/M2 and/or peripheral manifestations (e.g. oliguria) of low cardiac output present for 6 or more hours following surgery requiring inotropic and/or intra-aortic balloon pump support.

388 MEDIASTINITIS SET

This determines whether the patient has a bacterial infection below the sternum requiring drainage and antimicrobial therapy diagnosed during the postoperative hospitalization or within 30 days following surgery.

389 REOPERATION FOR BLEEDING SET
This determines whether the patient had any re-exploration of the thorax for suspected bleeding during the postoperative hospitalization.

390 STROKE SET
This determines whether the patient had any new objective neurologic deficit lasting 30 minutes or more with onset intraoperatively or occurring within 30 days following surgery.

391 REPEAT CARDIOPULMONARY BYPASS SET
This determines whether the patient had a repeat operation on the heart requiring cardiopulmonary bypass occurring after the patient has left the operating room from the initial operation and prior to discharge.

392 OTHER OCCURRENCES (ICD9) POINTER
This is the ICD Diagnosis Code for any other occurrence which does not fit in any other occurrence category.

393 RE-TRANSMISSION NUMERIC
This determines whether the assessment will be re-transmitted. It will automatically be set to '1' when a transmitted assessment is updated to an INCOMPLETE status to edit and re-transmit.

394 HISTORY OF MI SET
This determines whether the patient has a history of a non-Q wave, or a Q wave infarct in the 6 months prior to surgery as diagnosed in the patient's medical record.

395 ANGINA ONE MONTH PRIOR SET
This determines whether the patient had angina within one month prior to surgery. Angina is defined as pain or discomfort between the diaphragm and the mandible resulting from myocardial ischemia. Typically it is a dull, diffuse (fist sized or larger) substernal chest discomfort precipitated by exertion or emotion and relieved by rest or nitroglycerine. Radiation often occurs to the arms and shoulders and occasionally to the neck, jaw (mandible, not maxilla), or interscpular region.

396 CHF WITHIN ONE MONTH SET

This determines whether the patient has had congestive heart failure within one month prior to surgery. CHF is defined as the inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. Common manifestations are:

1. abnormal limitation in exercise tolerance due to dyspnea or fatigue
2. orthopnea (dyspnea on lying supine)
3. paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
4. increased jugular venous pressure
5. pulmonary rales on physical examination
6. cardiomegaly
7. pulmonary vascular engorgement

This may be noted in the medical record as CHF, congestive heart failure, or pulmonary edema.

397 SEVERE HEAD TRAUMA (Y/N) SET

This determines whether the patient has sustained open or closed trauma to the head from external force, violence, or accident with resulting impairment in neurological function as manifested by motor, sensory, or cognitive impairments.

398 QUADRIPLEGIA (Y/N) SET

This determines whether the patient has sustained acute or chronic neuromuscular injury resulting in total or partial paralyisi or paresis (weakness) of all four extremities.

399 PARAPLEGIA (Y/N) SET

This determines whether the patient has sustained acute or chronic neuromuscular injury resulting in total or partial paralysis or paresis (weakness) of the lower extremities.

400 HEMIPLEGIA (Y/N) SET

This determines whether the patient has sustained acute or chronic neuromuscular injury resulting in total or partial paralysis or paresis (weakness) of one side of the body.

401 TUMOR INVOLVING CNS (Y/N) SET

This determines whether the patient has a tumor involving the central nervous system. It is further defined as space occupying lesions of the brain, which may be benign (e.g., meningiomas, ependymoma, oligodendroglioma)

or primary (e.g., astrocytoma, glioma, glioblastoma multiform), or secondary malignancies (e.g., metastatic lung, breast, malignant melanoma). Other tumors that may involve the CNS include lymphomas and sarcomas.

402 GENERAL (Y/N) SET
This determines whether the patient has any general medical problems, such as diabetes, dyspnea, or alcohol related illnesses.

403 WOUND OCCURRENCES SET
This determines whether the patient had any postoperative wound occurrences.

404 WOUND DISRUPTION SET
This determines whether the patient has a wound disruption. Wound disruption is defined as separation of the layers of a surgical wound, which may be partial or complete, with disruption of the fascia.

405 LOW SERUM SODIUM FREE TEXT
This is the lowest postoperative serum sodium result recorded within 30 days postoperatively. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

406 LOW POTASSIUM FREE TEXT
This is the lowest recorded postoperative potassium result. Data input must be 1 to 3 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

407 LOW SODIUM, DATE DATE/TIME
This is the date that the lowest serum sodium test result was recorded.

408 LOW POTASSIUM, DATE DATE/TIME
This is the date that the lowest potassium test result was recorded.

409 RENAL INSUFFICIENCY SET
This determines whether the patient has a reduced capacity of the kidney to perform its function as evidenced by a rise in creatinine of greater than 2 mg/dl from the preoperative value, but no requirement for dialysis.

410 COMA > 24 HOURS POSTOP SET

This determines whether the patient was in a coma greater than or equal to 24 hours postoperatively. Coma is defined as significantly impaired level of consciousness (exclude transient disorientation or psychosis) for greater than or equal to 24 hours during the postoperative hospitalization.

411 CARDIAC ARREST REQ CPR SET
This determines if the patient has experienced any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) of any duration occurring in the operating room, ICU, ward, or out-of-hospital after the chest has been completely closed and within 30 days following surgery. Exclude intentional arrests during cardiac surgery.

412 UNPLANNED INTUBATION (Y/N) SET
This determines whether the patient required placement of an endotrachial tube and mechanical or assisted ventilation because of the onset of cardiac or respiratory failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

413 TRANSFER STATUS SET
Enter the number of the selection that best describes the healthcare facility from which this patient was directly transferred and admitted to this VA Medical Center.

(1) Not transferred and admitted directly from another healthcare facility
(2) Non-VAMC Acute Care Hospital
(3) VAMC Acute Care Hospital
(4) Non-VA Nursing Home/Chronic Care Facility/Spinal Cord Injury Unit/Intermediate Care Unit
(5) VA Nursing Home/Chronic Care Facility/Spinal Cord Injury Unit/Intermediate Care Unit
(6) Other

Determine if the patient was transferred from another healthcare facility and admitted directly from that facility to this VAMC. If transferred, determine whether the transferring facility was another VAMC acute care hospital; a non-VAMC acute care facility; a non-VHA nursing home, chronic care facility, spinal cord injury center or intermediate care facility; or a VHA nursing home, chronic care facility, or spinal cord injury center or intermediate care facility. If you cannot determine what kind of facility, enter OTHER.

414 CARDIAC SURGICAL PRIORITY SET
If this is a cardiac procedure, this is the surgical priority reflecting the patient's cardiovascular condition at the time of transport to the operating room:

1. Elective - Patient placed on elective schedule with surgery usually performed > 72 hours following catheterization.
2. Urgent - Clinical condition mandates prompt surgery usually within 12 to 72 hours of catheterization (patients clinically stable on a circulatory support system should be included in this category).
3. Emergent (ongoing ischemia) - Clinical condition mandates immediate surgery usually on day of catheterization because of ischemia despite medical therapy, such as intravenous nitroglycerine. Ischemia should be manifested as chest pain and/or ST-segment depression.
4. Emergent (hemodynamic compromise) - Persistent hypotension (arterial systolic pressure < 80 mm Hg) and/or low cardiac output (cardiac index < 2.0 L/min/MxM) despite iontropic and/or mechanical circulatory support mandates immediate surgery within hours of the cardiac catheterization.
5. Emergent (arrest with CPR) - Patient is taken to the operating room in full cardiac arrest with the circulation supported by cardiopulmonary resuscitation (excludes patients being adequately perfused by a cardiopulmonary support system).

414.1 SURGICAL PRIORITY, DATE DATE/TIME

This is the date and time that the cardiac surgical priority information was collected.

415 MITRAL REGURGITATION SET

This is the severity of mitral regurgitation. This question should be answered using either the left ventricular angiogram or the cardiac ultrasound examinations. You may convert adjectives used to describe the severity of the mitral regurgitation on the cardiac catheterization report to the four-point scale below. If a scale of +1 to +4 was used, 1+ = mild, 2 or 3+ = moderate, and 4+ = severe.

Diagnosis by Angiogram: The following definitions should be used to assess the presence/severity of mitral regurgitation based on the interpretation of the contrast left ventricular angiogram:

0. None: There is no visible systolic regurgitation across the mitral valve.
1. Mild: Definite contrast can be seen in the left atrium following left ventricular injection, but the left atrium never fills to the same opacity as the left ventricle.
2. Moderate: The left atrium fills to the same opacity as the left ventricle over two or more systoles.
3. Severe: The left atrium fills to the same opacity as the left ventricle over a single systole.

Diagnosis by Cardiac Ultrasound Examination: The following definitions are commonly used to assess the presence/severity of mitral regurgitation based on the interpretation of the cardiac ultrasound examination:
0. None: No regurgitant jet is seen on the Doppler study.
1. Mild: The area of regurgitant jet is 0-4 square centimeters.
2. Moderate: The area of regurgitant jet is 4-8 square centimeters.
3. Severe: The area of regurgitant jet is greater than 8 square centimeters or one third greater than the total left atrial area.

416 NUMBER WITH OTHER CONDUIT NUMERIC
This is the number of coronary artery bypass graft (CABG) anastomoses to native coronary arteries with other conduit(s) regardless of whether other procedures were performed. Do not leave this information blank. If no coronary artery bypass grafts with other conduits were performed, enter '0'.

417 RACE SET
This is the race of the patient. This is a standard set of codes and should not be edited.

418 HOSPITAL ADMISSION DATE DATE/TIME
This is the date and time of the hospital admission associated with this surgical case. Enter NA if this date is not applicable.

419 HOSPITAL DISCHARGE DATE DATE/TIME
This is the date of discharge. Enter NA if this date is not applicable.

Cardiac patients who remain as inpatients for reasons other than for post-open heart procedures should continue to be followed until discharged (including the rehabilitation service) even if the cardio-thoracic team discharges the patient from their service or would discharge the patient home. If the patient has subsequent surgeries please document them in comments section.

420 ADMISSION/TRANSFER DATE DATE/TIME
If the patient was not initially admitted to the surgical service, enter the date of transfer to surgical service for this surgical episode.

Enter NA if this date is not applicable.

421 DISCHARGE/TRANSFER DATE DATE/TIME
The date and time of the patient's discharge or transfer from the surgical or medical service to a chronic care setting, i.e., spinal cord injury unit, psychiatric facility or psychiatric unit, nursing home care unit or facility, or

intermediate medicine. Acute care beds must be established locally with the assistance of your station IRM service.

Enter NA if this date is not applicable.

430 CARDIAC RISK PREOP COMMENTS FREE TEXT
List any preoperative patient risk factors not recorded previously that may contribute to this patient's risk of operative mortality. The maximum length of this field is 130 characters.

431 CARDIAC RESOURCE DATA COMMENTS FREE TEXT
Record any comments pertaining to patient or the surgery. The maximum length of this field is 130 characters.

439 BATISTA PROCEDURE USED (Y/N) SET
Was the Batista procedure used, Yes or No?

440 CARDIAC CATHETERIZATION DATE DATE/TIME
Record the appropriate date of the most recent cardiac catheterization prior to surgery.

441 MINIMALLY INVASIVE PROC (Y/N) SET
Was a minimally invasive procedure technique used, Yes or No?

442 EMPLOYMENT STATUS PREOPERATIVE SET
Employment status preoperatively is to be defined in the broad sense of regularly performed work activity with remuneration.

443 TOTAL PREOP ICU LENGTH OF STAY NUMERIC
To determine the number of days the patient was in SICU/MICU prior to surgery from ICU admission to surgery date, check the VISTA nursing progress and transfer notes.

444 TOTAL POSTOP ICU LENGTH OF STY NUMERIC
To determine the number of days the patient was moved out of SICU/MICU from surgery date to transfer to ward or to death, check the VISTA nursing progress and transfer notes.

445 STEP DOWN UNIT LENGTH OF STAY NUMERIC
To determine the number of days the patient stayed postoperatively on the step-down-unit, check the VISTA nursing progress, and transfer notes.

450 TOTAL ISCHEMIC TIME NUMERIC
Record in minutes the duration of time the ascending aorta is totally cross-clamped. Do not include the duration of partial aorta cross-clamp used for sewing the proximal anastomoses.

451 TOTAL CPB TIME NUMERIC
Record in minutes the total cardiopulmonary bypass time. This includes the total duration of full and partial cardiopulmonary bypass from all episodes of cardiopulmonary bypass. This information can generally be found on the perfusionist record and/or the anesthesia record.

452 OBSERVATION ADMISSION DATE DATE/TIME
Following surgery, if the patient was admitted for observation, this is the date and time of admission for observation. If this information is not applicable, enter NA.

453 OBSERVATION DISCHARGE DATE DATE/TIME
If the patient was admitted for observation following surgery, this is the date and time of discharge from observation. If this information is not applicable, enter NA.

454 OBSERVATION TREATING SPECIALTY POINTER
If the patient was admitted for observation following surgery, this is the observation treating specialty to which the patient was admitted. If this information is not applicable, enter NA.

455 HIGHEST SERUM TROPONIN I FREE TEXT
This is the result of the highest postoperative serum cardiac troponin I test. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

455.1 HIGH SERUM TROPONIN I, DATE DATE/TIME
This is the date that the highest postop serum troponin I was performed.

456 HIGHEST SERUM TROPONIN T FREE TEXT
This is the result of the highest postoperative serum cardiac troponin T test. Data input must be 1 to 5 numeric characters in length which may include a prefix of a less than or greater than sign "<" or ">". Entering "NS" for "No Study" is also allowed.

456.1 HIGH SERUM TROPONIN T, DATE DATE/TIME
This is the date that the highest postop serum troponin T was performed.

901 AIRWAY INDEX SET

This field describes the degree of difficulty of airway management on a scale of 1 to 5, 1 being least difficult and 5 being most difficult. The value of this field is based on a computed performance index using the oral-pharyngeal (OP) class and the mandibular space (MS).

Performance index = 2.5 x OP - MS length (converted to centimeters)

Airway
Index
1 - Performance Index less than 0
2 - Performance index greater than 0 and less than 2
3 - Performance index greater than 2 and less than 3
4 - Performance index greater than 3 and less than 4
5 - Performance index greater than 4

901.1 ORAL-PHARYNGEAL SCORE SET

The Oral-Pharyngeal (OP) Score is determined with the patient in the sitting position with neck extended and tongue out.
Class 1: In the sitting position with head extended, soft palate, fauces, uvula, and anterior and posterior tonsilar pillars are seen.
Class 2: In the sitting position with head extended, soft palate, fauces, uvula are seen.
Class 3: In the sitting position with head extended, soft palate, base of uvula are seen.
Class 4: In the sitting position with head extended, soft palate is seen; uvula is not visible at all.

The OP score and the mandibular space (MS) are used in figuring a performance index which is translated to the patient's airway index.
(Performance Index = 2.5 x OP - MS length in cm)

901.2 MANDIBULAR SPACE NUMERIC

In the sitting position with head extended, enter the distance between the inside of the mentum and the top of the thyroid cartilage in millimeters. The mandibular space (MS) and the oral-pharyngeal (OP) score are used in figuring a performance index which is translated to the patient's airway index.
(Performance Index = 2.5 x OP - MS length in cm)

902 EVALUATING ANESTHETIST POINTER

This is the anesthetist or anesthesiologist who estimated the airway difficulty.

903 DEATH UNRELATED/RELATED SET
This indicates if death was unrelated to this surgery.

904 REVIEW OF DEATH COMMENTS WORD-PROCESSING
This word processing field contains comments about the review of death.

905 READY TO TRANSMIT? SET
This field is set to R (ready) by a MUMPS cross reference the TIME PAT OUT OR field. When this case is transmitted to the national database at the end of the quarter, this field will be updated to T (transmitted). This field serves as a flag that indicates the transmission status of this case.

2005 IMAGE POINTER
This sub-file contains pointers to images in the Imaging file (#2005) that are related to this case.

PERSON FIELD RESTRICTION (131)

This file is used to restrict entries into "person" type fields in other files. Each entry will contain a field name, file number, field number, and (site determined) keys to restrict entries. Fields in other files that will be restricted will call the routine SROXPR as part of the input transform. This will determine whether there are any restrictions and if so, whether the person selected has the proper keys to be entered into this field.

.01 FIELD IDENTIFIER FREE TEXT
This is the field identifier. It is the combination of a file (or sub-file) number and field number. These numbers are separated by a comma. Examples of typical entries are listed below.

1. 130.14 <-------- 130 is the file number of the SURGERY file and .14 is the field number of the SURGEON field contained in that file.

2. 130.28,.01 <------ 130.28 is the sub-file number of the OR CIRC SUPPORT sub-file of the SURGERY file. .01 is the OR CIRC SUPPORT field within the sub-file.

3 KEYS FREE TEXT
This field contains the key(s) used to restrict entries into this field.

.01 KEYS FREE TEXT
This is the name of the key that will be used to restrict entries into this field.

4 MODIFY LOCALLY SET
This determines whether the keys associated with this field can be modified at each individual medical center. If this field is set to '0', only the keys created by the initialization of the package will be used to restrict entries. The deletion or addition of keys will not be allowed.

5 COMMENTS WORD-PROCESSING
This contains any special comments related to this field or the keys used to restrict entries into it.

SURGERY TRANSPORTATION DEVICES (131.01)

This file contains devices used to transport the patient to and from the operating room. The file will be distributed with data which should not be altered, however sites may wish to add entries to this file.

.01 NAME FREE TEXT
This is the name of the device used to transport the patient to and from the Operating Room. Although this field is optional, it may be helpful in documentation of the case.

1 CODE FREE TEXT
This is the code corresponding to the device used to transport the patient to and from the Operating Room.

10 INACTIVE? SET
Enter "YES" to inactivate this entry to prevent its selection by Surgery users.

OPERATION TIMES (131.25)

This file stores the length of time it takes to do an operative procedure, based on the CPT code and surgical specialty.

.01 SURGICAL SPECIALTY POINTER
This is the name of the Surgical Specialty given credit for performing this operative procedure.

1 OPERATION POINTER
This is information related to the operative procedure.

.01 OPERATION POINTER
This is the CPT code corresponding to the principal operative procedure.

1 TOTAL MINUTES NUMERIC
This is the total number of minutes needed to perform all of the operative procedures with this CPT code.

2 TOTAL OPERATIONS NUMERIC
This is the total number of times that this operative procedure was performed.

SURGERY DISPOSITION (131.6)

This file contains entries describing the destination of the patient upon completion of the procedure: requested disposition, postoperative disposition or post-anesthesia care disposition.

.01 DISPOSITION FREE TEXT
This is the name of the surgery disposition.

1 CODE FREE TEXT
This optional code is used to facilitate disposition selection and lookup.

2 INACTIVE? SET
Enter 'YES' to inactivate this file entry and to prevent its selection by Surgery users.

3 SYNONYM FREE TEXT
.01 SYNONYM FREE TEXT
This sub-file contains other names by which this disposition may be known.

OPERATING ROOM (131.7)

This file contains information regarding the operating rooms. It includes a number of fields that cannot be edited using VA FileMan. Those fields include the PATTERN, BLOCK SCHEDULE DATE and SERVICE BLOCKOUT.

.01 NAME POINTER

This is the name of the operating room.

1 LOCATION FREE TEXT
This is the physical location of the operating room.

2 PERSON RESP POINTER
This is the name of the person responsible for this operating room.

3 TELEPHONE FREE TEXT
This is the telephone number of the operating room.

4 REMARKS FREE TEXT
These are comments relating specifically to this operating room.

6 SCHEDULE DATE DATE/TIME
This is information about the Schedule date.

.01 SCHEDULE DATE DATE/TIME
This is the date used to display the scheduling pattern.

1 PATTERN FREE TEXT
This is the pattern displaying scheduled cases for this operating room.

7 BLOCK SCHEDULE DATE DATE/TIME
This is the block schedule date. This field should not be modified through Fileman.

.01 BLOCK SCHEDULE DATE DATE/TIME
This is the block schedule date.

1 PATTERN FREE TEXT
This is the pattern stored for the block schedule date.

8 SERVICE BLOCKOUT FREE TEXT
This is information related to service blockouts.

.01 DAY FREE TEXT
This is the day of the week for this blockout.

1 SERVICE FREE TEXT
This is information related to the service for which the operating room time will be blocked out.

.01 SERVICE FREE TEXT
This is the name of the service.

1 START TIME FREE TEXT
This is information related to the start time of this blockout.

.01 START TIME FREE TEXT
This is the time that the blockout begins.

1 END TIME FREE TEXT
This is the time that the blockout ends.

2 HOW OFTEN FREE TEXT
This indicates how often this blockout should occur. For example, every week, once per month, or every other week.

2 SCHEDULED BY POINTER
This is the name of the person blocking out time on the display for this operating room.

9 TYPE POINTER
This is the operating room type.

10 CLEANING TIME NUMERIC
This is the average number of minutes required to clean this operating room after completion of a case. It will be used in determining operating room utilization.

11 NORMAL DAILY SCHEDULE SET
This is the normal daily schedule for each operating room.

.01 DAY OF THE WEEK SET
This is the day of the week (Sunday, Monday, Tuesday, etc.). Each day of the week will have a start time and end time associated with it for each operating room if using a normal daily schedule. If the room is not used on the selected day of the week, you can "flag" it as inactive.

1 NORMAL START TIME FREE TEXT
This is the usual time of day when this operating room goes into use. This entry must be in military time format with leading zeros. For example, a time of 7:00 AM MUST be entered in the format 07:00. The time 7:00 PM would be entered 19:00. If this operating room is not normally scheduled for use on this day, leave this field blank.

2 NORMAL END TIME FREE TEXT
This is the usual time of day after which this operating room is not scheduled for use. This entry must be in military time format with leading zeros. For example, a time of 7:00 PM MUST be entered in the format 07:00. The time 7:00 PM would be entered 19:00. If this operating room is not normally scheduled for use on this day of the week, leave this field blank.

3 INACTIVE (Y/N) SET
If this operating room is normally inactive on this day of the week, enter 'YES'. If this operating room is normally active on this day of the week, enter 'NO' or leave blank. This field is used in determining the utilization of this operating room.

99 INACTIVE? SET
Enter 'YES' to make this operating room inactive and to prevent its selection and use by users of the Surgery package. A 'YES' in this field indicates that this operating room is not in service.

SURGERY UTILIZATION (131.8)

This file contains information related to operating room and surgical specialty utilization. Start and end times for each room will be stored for each specific date.

.01 UTILIZATION DATE DATE/TIME
This is the date for which the utilization will be calculated.

1 OPERATING ROOM POINTER
This contains information related to the start and end times for all operating rooms on a specific date.

.01 OPERATING ROOM POINTER
This is the name of the operating room.

1 START TIME DATE/TIME
This is the time of day that this operating room begins functioning on the date selected.

2 END TIME DATE/TIME

This is the time that this operating room stops functioning on this date. It will be used when generating the operating room utilization reports.

3 INACTIVE (Y/N) SET
This flags the operating room if inactive on the date selected.

2 SURGICAL SPECIALTY POINTER
This is information related to the start and end times for each Surgical Specialty on a given date.

.01 SURGICAL SPECIALTY POINTER
This is the name of the Surgical Specialty.

1 START TIME DATE/TIME
This is the time of day that this Surgical Specialty begins functioning on this date. Any time entered prior to the start time will be considered overtime.

2 END TIME DATE/TIME
This is the time of day that this Surgical Specialty stops functioning. Any time worked after this time will be considered overtime.

3 INACTIVE (Y/N) SET
This flags the surgical specialty if it is inactive on this particular date.

PROSTHESIS (131.9)

This file contains prosthetic devices used by the Surgery package. The file is distributed with no pre-supplied entries. Sites must add entries as needed.

.01 NAME FREE TEXT
This is the name of the Prosthsis.

1 VENDOR FREE TEXT
This is the name of the manufacturer of the implanted prosthetic device.

2 MODEL FREE TEXT
This is the model of the implanted prosthetic device.

3 STERILE CODE FREE TEXT
This is the Sterilization Number/Code identifying the implanted prosthetic device.

4 LOT/SERIAL NO FREE TEXT

This is the Lot/Serial Number of the implanted prosthetic device.

5 STERILE RESP SET
This is the code corresponding to the party responsible for the sterilization of the implanted device.

6 SIZE FREE TEXT
This is the size of the implanted prosthetic device.

7 QUANTITY NUMERIC
This is quantity of the prosthetic device used for the procedure.

10 INACTIVE? SET
Enter "YES" to make this entry inactive and to prevent its selection and use by users of the Surgery Package.

SURGERY POSITION (132)

This file contains the various positions that a patient may be in during an operation. It is pointed to by the SURGERY POSITION field in the Surgery file. The file is distributed with pre-supplied entries, however sites may wish to make additions to it.

.01 NAME FREE TEXT
This is the name of the Surgery Position.

4 *MAJOR POSITION FREE TEXT
This field has been marked for deletion in the next release of the Surgery package.

5 CODE FREE TEXT
This is the code corresponding to the name of the Surgery Position.

10 INACTIVE? SET
Enter "YES" to inactivate this file entry and to prevent its selection by Surgery users.

RESTRAINTS AND POSITIONAL AIDS (132.05)

This file contains all restraints and positioning aids to be used in the operating room. The file is pointed to by the field RESTR & POSITION AIDS in the Surgery file. The file is pre-supplied with entries; however, each site may want to make additions to it.

.01 NAME FREE TEXT
This is the name of the restraint or positioning aid.

10 INACTIVE? SET
Enter "YES" to inactivate this file entry and to prevent it selection by Surgery users.

SURGICAL DELAY (132.4)

This file will contain causes for delays of surgical procedures. Sites may make additional entries to this file, but should not alter the entries provided. It is pointed to by the field DELAY CAUSE in the Surgery file.

.01 CAUSE FREE TEXT
This is the cause of the surgical delay.

10 INACTIVE? SET
Enter "YES" to make this entry inactive and to prevent its selection and use by users of the Surgery Package.

ANESTHESIA SUPERVISOR CODES (132.95)

This file is pointed to by the ANES SUPERVISE CODE in the Surgery file. It contains the codes representing the highest level of supervision for the anesthesiology supervisor. Sites should NOT make additional entries to this file.

.01 NAME FREE TEXT
This is the name of the Anesthesia Supervisor Code.

1 CODE FREE TEXT
This is the code corresponding to the principal anesthetist's level of supervision.

2 DESCRIPTION WORD-PROCESSING
This is a description of the anesthesia supervisor code.

SURGERY SITE PARAMETERS (133)

The Surgery Site Parameters file contains elements to the Surgery package that may be specific to each individual site.

.01 SITE POINTER
This is the institution responsible for the Surgery service. If the facility is multi-divisional, there will be more than one entry in this file.

3 MAIL CODE FOR ANESTHESIA FREE TEXT
This is the mail code for the Anesthesia service. It will be used to flag Anesthesiologists on the Anesthesia AMIS.

6 CANCEL IVS SET
This indicates whether all IV orders will be canceled upon entry into the operating room.

8 DEFAULT BLOOD COMPONENT FREE TEXT
This field contains the default blood type used during surgery. If a certain type is used frequently, this field should be completed.

9 CHIEF'S NAME FREE TEXT
This is the name of the Chief of Surgery. The name will be displayed on management reports.

10 LOCK AFTER HOW MANY DAYS NUMERIC
This is the number of days a case can be edited, after completion, without needing the Chief of Surgery's approval.

11 REQUEST DEADLINE FREE TEXT
This field is the time on the request cutoff day after which no requests can be made for a date. Your answer must be in a military time format with leading zeros. For example, a time of 7:00 AM MUST be entered in the format 07:00. The time 7:00 PM would be entered 19:00.

12 OR SCHEDULE DEVICES FREE TEXT
This contains all devices which will be used when the Schedule of Operationsis printed.

.01 OR SCHEDULE DEVICES FREE TEXT
This is the name of the printer used to automatically print the Schedule of Operations.

13 SCHEDULE CLOSE TIME FREE TEXT
This field contains the time of day at which the surgery schedule for the following day is considered to be closed. Any scheduled cases canceled after this time will be included in computing the cancellation rate for the facility. The time entered in this field may be earlier than, but no later than, 15:00. Your answer must be in a military time format with leading zeros. For example, a time of 9:00 AM MUST be entered in the format 09:00. 15:00 is the default time for this field if no time is entered.

14 VERSION NUMBER FREE TEXT
This field contains the current version number of the Surgery software.

15 RISK ASSESSMENT IN USE (Y/N) SET
This determines whether the Surgery Risk Assessment Module is being used at this facility. If so, enter 'YES'. A set of additional data elements will be prompted for during the requesting process if the risk assessment module is in use. If you are not using the Surgery Risk Assessment Module, enter 'NO'.

16 LATEST CASE WORKLOAD REPORT DATE/TIME
This field contains the date (month/year) of the latest NSQIP monthly case workload report automatically tasked for transmission to the national database. This field is an uneditable field and is set automatically when the monthly case workload report is transmitted by way of the nightly task process.

17 ASK FOR RISK PREOP INFO SET
Enter YES if the user should be prompted for risk assessment preoperative information when entering a new case and when updating a requested or scheduled case.

18 UPDATES TO PCE SET
This indicates the site's preference for PCE updating. If this field contains O, PCE will be updated with outpatient case information only. If this field contains A, PCE will be updated with information from all cases, both inpatient and outpatient. If this field contains N or is null, no PCE updating will occur.

18.5 PCE UPDATE ACTIVATION DATE DATE/TIME
This is the earliest date of operation for which surgical cases may be filed with PCE. Surgical cases or non-OR procedures performed before this date will not be filed with PCE. If no date is entered, this parameter will be ignored.

19 ASK CLASSIFICATION QUESTIONS SET

This field indicates whether the patient service connected classification questions should be asked when entering a new case or when updating an existing case.

20 REQUEST CUTOFF FOR SUNDAY SET
Enter the day of the week on which the request deadline occurs for Sunday scheduling. Enter '0' if Sunday scheduling is not allowed. If no entry is made in this field, the package will assume the request cutoff day for Sunday is Saturday.

21 REQUEST CUTOFF FOR MONDAY SET
Enter the day of the week on which the request deadline occurs for Monday scheduling. Enter '0' if Monday scheduling is not allowed. If no entry is made in this field, the package will assume the request cutoff day for Monday is Sunday.

22 REQUEST CUTOFF FOR TUESDAY SET
Enter the day of the week on which the request deadline occurs for Tuesday scheduling. Enter '0' if Tuesday scheduling is not allowed. If no entry is made in this field, the package will assume the request cutoff day for Tuesday is Monday.

23 REQUEST CUTOFF FOR WEDNESDAY SET
Enter the day of the week on which the request deadline occurs for Wednesday scheduling. Enter '0' if Wednesday scheduling is not allowed. If no entry is made in this field, the package will assume the request cutoff day for Wednesday is Tuesday.

24 REQUEST CUTOFF FOR THURSDAY SET
Enter the day of the week on which the request deadline occurs for Thursday scheduling. Enter '0' if Thursday scheduling is not allowed. If no entry is made in this field, the package will assume the request cutoff day for Thursday is Wednesday.

25 REQUEST CUTOFF FOR FRIDAY SET
Enter the day of the week on which the request deadline occurs for Friday scheduling. Enter '0' if Friday scheduling is not allowed. If no entry is made in this field, the software will use Thursday as the request cutoff day for Friday.

26 REQUEST CUTOFF FOR SATURDAY SET

Enter the day of the week on which the request deadline occurs for Saturday scheduling. Enter '0' if Saturday scheduling is not allowed. If no entry is made in this field, the package will assume the request cutoff day for Saturday is Friday.

27 HOLIDAY SCHEDULING ALLOWED POINTER
These are the holidays on which the scheduling of surgical cases will be allowed.

28 REQUIRED FIELDS FOR SCHEDULING POINTER
This contains the names of fields that must be entered prior to scheduling a requested procedure.

.01 REQUIRED FIELDS FOR SCHEDULING POINTER
This is the name of a field that must have information entered prior to scheduling. If this field does not have the information entered, scheduling will be prohibited.

1 COMMENTS WORD-PROCESSING
This contains any comments related to why this field was included as a requirement for scheduling.

29 NURSE INTRAOP REPORT SET
This determines the format of the Nurse Intraoperative Report. Enter '1' if you want to list all field titles in the report regardless as to whether information has been entered for that field. If you want a shorter report, enter '0'. This format will print only those fields that have information entered. If nothing is entered for this parameter, the report will include all field titles.

30 OPERATION REPORT FORMAT SET
This determines the format of the Operation Report. If you want to display all field titles on the report and 'N/A' for those fields that do not have information entered, select format '1'. If you only want to display field titles when information has been entered, select format '0'.

32 LATEST QUARTERLY REPORT FREE TEXT
This field contains the latest fiscal quarter for which the Quarterly Report has been transmitted to the Surgical Service Headquarters national database.

33 SURGICAL RESIDENTS (Y/N) SET
This field indicates whether surgery may be performed by residents at this facility. Enter NO if all surgeons at this facility are staff surgeons. If this

field is NO an attending surgeon will not be required by the PCE interface and cases with no attend code will be counted as Level 0 (Staff Alone) on the Quarterly Report.

34 HL7 V. 1.5 COMPATIBLE SET
If applications communicating with the Surgery HL7 interface must use the interface designed for use with HL7 V. 1.5, enter YES. Otherwise, enter NO or leave this field blank.

35 INACTIVE? SET
Enter YES to make this SURGERY SITE inactive and to prevent its selection and use by Surgery users.

36 CPT COPYRIGHT NOTICE DATE DATE/TIME
.01 CPT COPYRIGHT NOTICE DATE DATE/TIME
The date in this multiple field represents the most recent date(s) on which the CPT copyright notice was displayed to users upon entering the Surgery package.

1 USER POINTER
.01 USER POINTER
This multiple field records the users to whom the CPT copyright notice has been displayed on this date.

37 AUTOMATED CASE CART ORDERING: SET
This field indicates whether or not the CoreFLS interface is in use at the facility. If so, enter YES. Otherwise, enter NO or leave the field blank.

SURGERY INTERFACE PARAMETER (133.2)

The Surgery package uses this file for its HL7 interface with **V*IST*A** and Non- **V*IST*A** packages or systems. The file acts as a mapping and processing tool for receiving information from other applications and transmitting information from the Surgery package.

Data in this file SHOULD NOT be altered through the use of VA FileMan; input to this field should only take place through the Surgery Interface Management Menu options.

Per VHA Directive 10-93-142, this file definition SHOULD NOT be modified.

.01 TEXT FREE TEXT
This field is used to map **V*IST*A** fields to HL7 (OBR-4 and OBX-3 identifiers) segment sequences. This field is used as a text identifier for the field number.

1 FILE/SUBFILE NUMERIC
This field holds the FILE/SUBFILE number of the **V*IST*A** field that will be edited (e.g. 130).

2 FIELD NUMERIC
This is the corresponding **V*IST*A** field number of the text name that will be passed in either the OBX-3 or OBR-4 sequence.

3 INTERFACE SET
This field is used to determine ownership of data among systems. Data should be entered in this field. Except for OBR segment identifiers like OPERATION and PROCEDURE that do not have a FILE/SUBFILE and FIELD associations, all other entries should be set to send, receive or ignore. Excluding these entries will allow the users to send or receive individual pieces of underlying information related to the operation or procedure. If the field is set to R, the information will be received into the Surgery package. If the field is set to S, the information will be transmitted from the Surgery package. If the field is not part of the interface the field should be set to I, for ignore.

4 SEGMENT FREE TEXT
This field identifies the HL7 segment that will be holding the information, (e.g., OBX).

5 VALUE SET
This field is used to identify the type of information being passed by the OBX segment. This field will be blank for all OBR segments.

6 HL7 SEQUENCE FREE TEXT
This field holds the HL7 sequence and field position of the corresponding **V*IST*A** field. The field should contain the sequence number separated by a dash ('-') and followed by the sub-component location (value should be 1 if no sub-component separator).

7 MESSAGE FREE TEXT
This field identifies the HL7 message sent for the information.

8 LEVEL NUMERIC
This field corresponds to the **V*IST*A** file location level in terms of a VA FileMan DIE call.

9 RELATED POINTER POINTER

This field is used to link the HL7 sequence fields in a single segment for processing in a DR string. This field should only link those fields located on a single segment.

.01 RELATED POINTER POINTER
This field is used as a reference pointer to the other related entries in this file. Related entries are those entries that corresponded to the same segment, but are at different HL7 sequence locations.

10 RELATED MENU ITEMS POINTER
This multiple is used to link all OBR segments to all underlying OBX segments.

.01 RELATED MENU ITEMS POINTER
This field is used to link OBR segments to all underlying OBX segments.

11 IDENTIFIER FREE TEXT
This field is used to base the code that relates to the identifier. HL7 standards call for information to be base in this form: <code><text><coding scheme>.

12 CODING SCHEME FREE TEXT
This field is used to base the coding scheme that relates to the identifier. The standard coding method is to use L for local fields and 99VAfile# (99VA200, NEW PERSON file) for VA specific files. Other coding schemes include AS4 for (ASTM) American Society for testing and materials, C4 for CPT4, and I9 for ICD9.

13 UNIT FREE TEXT
This field represent the identified field's unit of measure. This value must correspond to the ISO standards set forth by the HL7 standard.

14 ALWAYS CREATE NEW ENTRY SET
This field is used by the incoming message processing routine to determine if the value should always create a new entry in the file.

MONITORS (133.4)

This file contains invasive and non-invasive monitors used in the Surgery package. It is pointed to the MONITORS sub-field in the SURGERY file. The MONITORS

file is distributed with pre-supplied entries, however each site may want to make additions to it.

.01	NAME This is the name of the monitor.	FREE TEXT
10	INACTIVE? Enter "YES" to inactivate this file entry and to prevent its selection by Surgery users.	SET

IRRIGATION (133.6)

This file contains irrigation solutions used during the operative procedure. It is pointed to by the IRRIGATION sub-file in the SURGERY file. The IRRIGATION file is distributed with pre-supplied entries, however additions may be made at each site.

.01	NAME This is the name of the solution used for irrigation during the operative procedure.	FREE TEXT
1	ABBREVIATION This is the Abbreviation of the name of the irrigation solution.	FREE TEXT
10	INACTIVE? Enter "YES" to make this entry inactive and to prevent its selection and use by users of the Surgery Package.	SET

SURGERY REPLACEMENT FLUIDS (133.7)

This file contains replacement fluids used during the operative procedure. It is pointed to by the REPLACEMENT FLUIDS sub-file in the SURGERY file. The SURGERY REPLACEMENT FLUIDS file is distributed with pre-supplied entries, however additions may be made to it.

.01 NAME FREE TEXT
This is the name of the Surgery Replacement Fluid.

10 INACTIVE? SET
Enter "YES" to make this entry inactive and to prevent its selection and use by users of the Surgery Package.

SURGERY WAITING LIST (133.8)

This file contains information regarding the surgery waiting list for each surgical specialty. Patients entered into this file will later be moved into the SURGERY file at the point that a request for surgery is made.

.01 SURGICAL SPECIALTY POINTER
This is the name of the Surgical Specialty. All entries in the Waiting List file have an associated Surgical Specialty.

1 PATIENT POINTER
This sub-file contains information related to the patient that was placed on the waiting list.

.01 PATIENT POINTER
This is the name of the patient who will be put on the Waiting List for the Surgical Specialty selected.

1 OPERATION FREE TEXT
This is the name of the principal operative procedure. When this patient is scheduled from the Waiting List, the procedure name entered will automatically get carried over to the Schedule.

2 DATE ENTERED ON LIST DATE/TIME
This is the date/time that the patient was entered on the Waiting List. When displaying the list, entries are printed in the order in which they were entered.

3 REFERRING PHYSICIAN FREE TEXT
This is information related to the referring physician.

.01 REFERRING PHYSICIAN FREE TEXT
This is the name of the physician and/or medical center that referred the patient for surgery at this facility.

1 STREET ADDRESS FREE TEXT
This is the street address of the referring physician/medical center.

2 CITY FREE TEXT
This is the city where the referring physician/medical center is located.

3 STATE POINTER
This is the name of the state in which the referring physician/medical center is located.

4 ZIP CODE FREE TEXT
This is the referring physician/medical center's zip code.

5 PHONE NUMBER FREE TEXT
This is the telephone number of the referring physician/medical center.

4 COMMENTS WORD-PROCESSING
These are comments related to this patient which are displayed when printing the waiting list.

5 TENTATIVE ADMISSION DATE DATE/TIME
This field contains the expected admission date for this patient. The information is not required, but should be entered if known.

6 TENTATIVE DATE OF OPERATION DATE/TIME
This is the estimated date of operation for this procedure.

16 SERVICE CONNECTED SET
This field will be used to indicate if this surgery is treating a VA patient for a service connected problem. This information may be passed to the VISIT file (#9000010) to be used by PCE.

17 AGENT ORANGE EXPOSURE SET

This field will be used to indicate if this surgery is treating a VA patient for a problem that is related to Agent Orange Exposure. This information may be passed to the VISIT file (#9000010) to be used by PCE.

18 IONIZING RADIATION EXPOSURE SET
This field will be used to indicate if this surgery is treating a VA patient for a problem that is related to Ionizing Radiation Exposure. This information may be passed to the VISIT file (#9000010) to be used by PCE.

19 ENVIRONMENTAL CONTAMINANTS SET
This field will be used to indicate if this surgery is treating a VA patient for a problem related to environmental contaminant exposure. This information may be passed to the VISIT file (#9000010) to be used by PCE.

20 CLASSIFICATION ENTERED (Y/N) SET
This field indicates whether or not classification items have been addressed. This field is used by the software to decide whether to allow the user a choice to update classification information. If the field is NO or null, it will not permit a choice if the site parameter to enter classification information is turned on.

OPERATING ROOM TYPE (134)

This file contains information regarding the types of operating rooms. It is pointed to by the TYPE field in the OPERATING ROOM file. The OPERATING ROOM TYPE file is distributed with pre-supplied entries. Sites should not make additions to this file.

.01 NAME FREE TEXT
This is the name of the Operating Room Type. Entries in this file should not be modified locally.

1 CODE FREE TEXT
This is the code corresponding to the Operating Room Type. This information is standard nationally and should not be modified locally.

2 DESCRIPTION WORD-PROCESSING
This is a description of the operating room type.

SURGERY CANCELLATION REASON (135)

This file contains reasons for cancelling a scheduled operative procedure. It is pointed to by the CANCEL REASON field in the SURGERY file. The SURGERY CANCELLATION REASON file is distributed with pre-supplied entries, however sites may wish to add to it.

.01	NAME	FREE TEXT
	This is the name of the cancellation reason.	
1	CODE	FREE TEXT
	This is the code corresponding to the cancellation reason.	
2	AVOIDABLE	SET
	This field will be used as the default for the CANCELLATION AVOIDABLE field in the SURGERY file (130).	
10	INACTIVE?	SET
	Enter "YES" to inactivate this entry to prevent its selection by Surgery users.	

SKIN PREP AGENTS (135.1)

This file contains solutions used as skin prep agents for a surgical procedure. It is pointed to by the field SKIN PREP AGENT in the Surgery file. The file is distributed with pre-supplied entries, however sites may wish to make additions to it.

.01	NAME	FREE TEXT
	This is the name of the agent used to prepare the skin prior to the operative procedure.	
1	CODE	FREE TEXT
	This is the code corresponding to the skin preparation agent name.	
10	INACTIVE?	SET
	Enter "YES" to make this entry inactive and to prevent its selection and use by users of the Surgery Package.	

SKIN INTEGRITY (135.2)

This file contains entries describing the skin integrity of a patient before and after the operative procedure. It is distributed with pre- supplied entries, however sites may wish to make additions to it.

.01	NAME This field is the name used for the assessment of the patient's skin integrity.	FREE TEXT
1	CODE This is the code corresponding to the assessment of the patient's skin integrity.	FREE TEXT
10	INACTIVE? Enter "YES" to make this entry inactive and to prevent its selection and use within the Surgery Package.	SET

PATIENT MOOD (135.3)

This file contains entries regarding the assessment of the patient's mood before and after the operative procedure. It is distributed with pre-supplied entries, however sites may wish to make additions to it.

.01	NAME This is the assessment of the patient's mood.	FREE TEXT
1	CODE This is the code corresponding to the assessment of the patient's mood.	FREE TEXT
10	INACTIVE? Enter "YES" to inactivate this file entry and to prevent its selection by Surgery users.	SET

PATIENT CONSCIOUSNESS (135.4)

This file contains entries regarding the assessment of the patient's consciousness before and after the operative procedure. The file is distributed with pre-supplied entries. The sites may wish to make additions to it.

.01 NAME FREE TEXT
This is the assessment of the patient's consciousness.

1 CODE FREE TEXT
This is the code corresponding to the patient's level of consciousness.

10 INACTIVE? SET
Enter "YES" to inactivate this entry to prevent it from being selected by Surgery users.

SURGERY TRANSCRIPTION (136)

This file is used to temporarily store transcripted operation notes which have been transferred from another system. The operation notes will then be merged with the appropriate surgical case found in the SURGERY file (130).

.01 NAME POINTER
This is the name of the person creating this entry in the file.

1 TEXT WORD-PROCESSING
This is the text of the operation notes transferred from another system.

2 OP NOTES IN QUEUE POINTER
This field contains the cases for which the operation notes are in the queue to be printed.

.01 OP NOTES IN QUEUE POINTER
This field contains the cases for which the operation notes are in the queue to be printed.

1 LAST DATE PRINTED DATE/TIME
This field contains the last date/time that the operation notes for this case have been printed.

2 # OF LINES OF TEXT NUMERIC
This is the number of lines in the text of this operation note.

3 UNMERGED OP NOTES POINTER
This field contains cases in which the information in the heading for a transmitted operation note does not match an entry in the Surgery file (130).

.01 UNMERGED OP NOTES POINTER
This field contains cases in which the information in the heading for a

transmitted operation note does not match an entry in the Surgery file (130).

PERIOPERATIVE OCCURRENCE CATEGORY (136.5)

This file contains perioperative occurrence categories used within the **V*IST*A** Surgery package. All perioperative occurrences entered must be grouped into one of the categories contained in this file. The fields in this file are restricted so that entries cannot be altered.

.01 OCCURRENCE CATEGORY FREE TEXT
This field contains the name of the perioperative occurrence category to be used when categorizing surgical and anesthesia perioperative occurrences.

1 INACTIVE? SET
If this perioperative occurrence category is no longer used, enter YES to flag this category as INACTIVE.

2 DESCRIPTION WORD-PROCESSING
This is a description used to further define the perioperative occurrence type.

3 SYNONYM FREE TEXT
This is another name for this perioperative occurrence category.

.01 SYNONYM FREE TEXT
This is another name for this perioperative occurrence category.

4 INTRAOPERATIVE ALLOWED SET
If this occurrence category may be associated with an intraoperative occurrence, enter YES.

LOCAL SURGICAL SPECIALTY (137.45)

This file contains the Surgical Specialties used locally. This file contains all the entries in the national SURGICAL SPECIALTY file (45.3) as well as locally created entries. All entries should point to a standard entry in the national SURGICAL SPECIALTY file.

.01 NAME FREE TEXT
This is the name of the 'local' surgical specialty used at this site.

1 NATIONAL SURGICAL SPECIALTY POINTER
This is the 'national' surgical specialty in file 45.3 to which this 'local' specialty points.

2 ASSOCIATED CLINIC POINTER
This is the default clinic associated with operations or procedures performed by this surgical specialty. This information is used to document patient encounters in the VISIT file (#900010).

10 INACTIVE? SET
Enter 'YES' to make this specialty inactive and to prevent its selection and use by users in the Surgery Package.

11 CODE FREE TEXT
This is a code used for selecting local surgical specialties. Your answer may be a number, number/letter combination, or brief alphabetic code. The specialty code is optional.

ELECTROGROUND POSITIONS (138)

This file contains the various body sites to which the electroground can be applied.

.01 NAME FREE TEXT
This is the name of the Electroground Position.

1 CODE FREE TEXT
This is the code corresponding to the name of the electroground position.

10 INACTIVE? SET
Enter "YES" to inactivate this entry and to prevent its selection by Surgery users.

RISK MODEL LAB TEST (139.2)

This file contains the set of laboratory tests tracked by the Surgery Risk Assessment Module along with the corresponding local data names in file 63 pointed to by these tests and the appropriate specimens for these tests.

.01 NAME FREE TEXT
This is the laboratory test which will be tracked using the Surgery Risk Assessment Module.

1 LABORATORY DATA NAME POINTER

These are the local Data Names in file 63 pointed to by this lab test.

.01 LABORATORY DATA NAME POINTER
This is the local Data Name in file 63 pointed to by this lab test.

2 SPECIMEN POINTER
This is the specimen associated with this laboratory test.

Note: The RISK MODEL LAB TEST file is distributed with predefined laboratory Tests selected by the National Surgical Quality Improvement Program (NSQIP). These laboratory tests should not be added to nor deleted from the file unless directed by the NSQIP Executive Committee. The LABORATORY DATA NAME field (multiple entries allowed) for each laboratory test in this file must be reviewed and edited (using VA FileMan) to reflect the data names in the LAB DATA file (#63) that are actually used locally by the Laboratory package. It is likely that some laboratory tests in File #139.2 will match more than one data name in File #63. Similarly, the SPECIMEN field for each test should be reviewed and edited if necessary (using VA FileMan) to reflect the specimen used locally for the test by the Laboratory package. This process of file review and edit will require the combined efforts and cooperation of the Surgical Clinical Nurse Reviewer, the Laboratory Applications Coordinator, and the IRM staff.

Options

Option Descriptions

Admissions Within 14 Days of Outpatient Surgery SROQADM
This option provides a list of patients with completed outpatient surgical cases which resulted in at least one postoperative occurrence AND a hospital admission within 14 days of the surgery. These patients are included in the "Admitted Within 14 Days" total on the Quarterly Report.

Anesthesia AMIS SROAMIS
This report generates the Anesthesia AMIS report required by C.O.

Anesthesia Data Entry Menu SROANES-D
This menu contains options used to enter or edit anesthesia related information.

Anesthesia Information (Enter/Edit) SROMEN-ANES
This option is used to enter Anesthesia related information for a given case.

Anesthesia Menu SROANES1
This menu contains the various options used to enter and display information related to the anesthesia technique and personnel.

Anesthesia Provider Report SROADOC
This report provides information concerning the Anesthesia staff and technique for completed cases. It will sort the cases by the principal anesthetist.

Anesthesia Report SROARPT
This option generates the Anesthesia Report which contains all the anesthesia information for a case. It is locked by the SROANES security key.

Anesthesia Reports SR ANESTH REPORTS
This menu contains various anesthesia reports, including the Anesthesia AMIS and List of Anesthetic Procedures.

Anesthesia Technique (Enter/Edit) SROMEN-ANES TECH
This option will be used to enter information for the anesthesia technique used. Depending on what technique was used, a different set of fields may be entered.

Anesthesia for an Operation Menu SROANES
This menu contains the various Anesthesia related options used to input and display anesthesia staff and technique information.

Annual Report of Non-O.R. Procedures SRONOP-ANNUAL
This option is used to generate the Annual Report of Non-OR Procedures. It will display the total number of procedures based on CPT code.

Annual Report of Surgical Procedures SROARSP
This option is used to generate the Annual Report of Surgical Procedures required by C.O. It will count procedures within Surgical Specialties.

Attending Surgeon Reports SROATT
This option generates the Attending Surgeon Reports which display staffing information for completed cases along with cumulative totals for each attending code. It can be sorted by surgical specialty and can be generated for an individual surgeon.

Backfill Order File With Surgical Cases SROERR BACKFILL
This option allows the backfilling of the ORDER file with existing Surgical cases. The user must select the number of days back for which Surgical cases should be added to the ORDER file to update OE/RR.

Batch Print Operation Reports SRTASK-BATCH OP REPORTS
This option will be queued to run nightly. It will automatically print the operation reports for completed cases on the previous day.

Batch Print Transcripted Operation Notes SRSTRANS PRINT
This option is used to batch print transcribed operation notes using a word processor or micro computer. It will only print those notes transcribed by the logged on user.

Blood Product Verification SR BLOOD PRODUCT VERIFICATION
This option is contained on the Surgery "Operations Menu". After scanning the blood unit ID, the software will check for an association with the patient identified. If there are multiple entries with the Unit ID scanned, these entries will be listed along with the Blood Component, Patient Associated, and Expiration Date. The user will then be prompted to select the one that matches the blood product about to be administered. If the selected product is not associated with the patient identified, the warning message will be displayed.

CPT Code Reports SR CPT REPORTS
This menu contains reports based on CPT Codes. It includes the Cumulative Report of CPT Codes, Report of CPT Coding Accuracy, and the Report of Cases Missing CPT Codes.

CPT/ICD9 Coding Menu SRCODING MENU
This menu provides functionality for reviewing operations and non-OR procedures and for editing operation and non-OR procedure CPT and ICD9 codes.

CPT/ICD9 Update/Verify Menu SRCODING UPDATE/VERIFY MENU
This menu contains options to be used by those responsible for entering CPT and ICD9 codes for operations and non-OR procedures.

Cancel Scheduled Operation SRSCAN
This option will be used to cancel a scheduled operation on a given date. When a scheduled case is cancelled, a new request will be automatically generated for that case on the same date.

Cardiac Procedures Requiring CPB (Enter/Edit) SROA CARDIAC PROCEDURES
This option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass for the cardiac surgery risk assessments.

Cardiac Risk Assessment Information (Enter/Edit) SROA CARDIAC ENTER/EDIT
This menu contains options to enter or edit assessment information for the cardiac risk assessments.

Chief of Surgery Menu SROCHIEF
This menu contains the various options designed for use by the Chief of Surgery and his package coordinator.

Circulating Nurse Staffing Report SROCNR
This report provides nurse staffing information, sorted by the circulating nurses' name.

Clinical Information (Enter/Edit) SROA CLINICAL INFORMATION
This option is used to enter the clinical information required for the cardiac surgery risk assessments.

Comments SROMEN-COM
This option will be used to enter general comments about a case.

Comparison of Preop and Postop Diagnosis SROPPC
This report contains completed cases in which the principal preoperative and principal postoperative diagnoses are different.

Convert Risk Assessment Data SROA CONVERT
This option is used to convert the data entered through the stand alone Surgery Risk Assessment Module into the SURGERY file (130). Each entry in the SURGERY RISK ASSESSMENT file (139) will be merged into the SURGERY file or removed from your system. Upon completion of this option, and no entries remaining in the SURGERY RISK ASSESSMENT file, the SURGERY RISK ASSESSMENT file (139) will be deleted from your system. This option will then self destruct.

Create Service Blockout SRSBOUT
This option is used to block out times on the OR schedule by surgical specialty.

Cumulative Report of CPT Codes SROACCT
This report displays the total number of each CPT code entered for the date range selected. It also breaks down the totals into two categories, principal procedures and other operative procedures.

Deaths Within 30 Days of Surgery SROQD
This option lists patients who had surgery within the selected date range, who died within 30 days of surgery and whose deaths are included on the Quarterly/Summary Report. Three separate reports are available through this option corresponding to the three sections of the Quarterly Report that include death totals.

1. Total Cases Summary
   This report may be printed in one of three ways.
   A. All Cases
      The report will list all patients who had surgery within the selected date range and who died within 30 days of surgery, along with all of the patients' operations that were performed during the selected date range. These patients are included in the postoperative deaths totals on the Quarterly Report.
   b. Outpatient Cases Only
      The report will list only the surgical cases that are associated with deaths that are counted as outpatient (ambulatory) deaths on the Quarterly Report.
   c. Inpatient Cases Only
      The report will list only the surgical cases that are associated with deaths that are counted as inpatient deaths. Although the count of deaths associated with inpatient cases is not a part of the Quarterly Report, this report is provided to help with data validation.
2. Specialty Procedures
   This report will list the surgical cases that are associated with deaths that are counted for the national surgical specialty linked to the local surgical specialty. Cases are listed by national surgical specialty.

3. Index Procedures
   This report will list the surgical cases that are associated with deaths that are counted in the Index Procedures section of the Quarterly Report.

Delay and Cancellation Reports SRO DEL MENU
This menu contains various reports used to track delays and cancellations.

Delete Service Blockout SRSBDEL
This option is used to delete service blockouts already existing on a schedule.

Delete a Patient from the Waiting List SROW-DELETE
This option is used to delete a patient currently on the surgery waiting list for a selected service.

Delete or Update Operation Requests SRSUPRQ
This option will be used to delete, change the date, or update the information entered on a requested operation.

Display Availability SRODISP
This option provides a graph of the availability of operating rooms. Times that are unavailable will be marked by 'X's.

Edit Non-O.R. Procedure SRONOP-EDIT
This option allows the editing of information on the pre-selected non-OR procedure.

Edit a Patient on the Waiting List SROW-EDIT
This option is used to edit a patient already on the waiting list for a selected surgical specialty.

Enter Cardiac Catheterization & Angiographic Data SROA CATHETERIZATION
This option is used to enter or edit cardiac catheterization and angiographic information for cardiac surgery risk assessments.

Enter Irrigations and Restraints SROMEN-REST
This option is used to stuff in multiple restraints and positioning aids.

Enter PAC(U) Information SROMEN-PACU
This option is used to enter or edit recovery room scores and times.

Enter Referring Physician Information SROMEN-REFER
This option is used to enter the name, phone number and address of the referring physician or institution.

Enter Restrictions for 'Person' Fields SROKEY ENTER
This option is used to enter restrictions on person fields. It will allow you to add keys to existing entries in the PERSON FIELD RESTRICTION file. If the field to be restricted has not already been entered in the PERSON FIELD RESTRICTION file, you may enter it along with the restricting keys through this option.

Enter a Patient on the Waiting List SROW-ENTER
This option is used to enter a patient on the waiting list for a selected surgical specialty.

Enter/Edit Date of Dictation SROCHDD
This option is used to enter or edit the date that this case has been dictated.

Exclusion Criteria (Enter/Edit) SR NO ASSESSMENT REASON
This option is used to flag major cases that will not have a surgery risk assessment due to certain exclusion criteria.

File Download SRHL DOWNLOAD INTERFACE FILES
This option is used to download Surgery interface files to the Automated Anesthesia Information System (AAIS). The process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Flag Drugs for Use as Anesthesia Agents SROCODE
This option is used to flag drugs for use as anesthesia agents. Only those drugs that are flagged will be available when selecting anesthesia agents.

Flag Interface Fields SRHL INTERFACE FLDS
This option allows the package coordinator to set the INTERFACE field in the SURGERY INTERFACE file (#133.2). The categories listed on the first screen correspond to entries in File 133.2. These categories are listed in the Surgery Health Level 7 Interface Specifications document as being the OBR (Oservation Request) text identifiers. Each identifier corresponds to several fields in the VistA Surgery package. This allows the user to control the flow of data between the VistA Surgery package and the ancillary system on a field by field basis.

The option lists each identifier and its current setting. To receive the data coming from the ancillary system for a category, set the flag to R for receive. To ignore the data, set the flag to N for not receive. To see a second underlying layer of OBX text identifiers (fields in File 130) and their settings, set the OBR text identifier to RR

for receive. The option will allow the user to toggle the settings for a range or for individual items.

Intraoperative Occurrences (Enter/Edit) SRO INTRAOP COMP
This option is used to enter or edit intraoperative occurrences. Every occurrence entered must have a corresponding perioperative occurrence category.

Laboratory Interim Report SRO-LRRP
This option will print or display interim reports for a selected patient, within a given time period. The printout will go in inverse date order. This report will output all tests for the time period specified. If no results are available, the option will ask for another patient. This option will only print verified results and at present does not output the microbiology reports.

Laboratory Test Results (Enter/Edit) SROA LAB
This option is used to enter or edit laboratory information for an individual risk assessment.

List Completed Cases Missing CPT Codes SRSCPT
This option will generate a report of completed cases that are missing a CPT code for the principal or secondary operation(s). It is important to note that only procedures that have CPT codes will be counted on the Annual Report of Surgical Procedures.

List Operation Notes in the 'Print' Queue SRSTRANS PQ
This option lists the most recent transmitted operation notes which were sucessfully merged with a case in the Surgery file.

List Operation Requests SRSRBS
This option is designed to list requested cases, including those patients on the waiting list. It will print all future requests, sorted by ward location or surgical specialty.

List Scheduled Operations SRSCD
This option is designed to provide a short form listing of scheduled cases for a given date. It will sort by surgical specialty, operating room, or ward location and is designed to be displayed on your CRT.

List of Anesthetic Procedures SROANP
This option generates the List of Anesthetic Procedures for a specified date range.

List of Invasive Diagnostic Procedures SROQIDP

This option provides a report listing the completed surgical cases that were performed during the selected date range and that have a principal CPT code on the list defined by Surgical Service at VHA Headquarters as invasive diagnostic procedures.

List of Operations SROPLIST
This report contains general information for completed cases within a selected date range. It includes the procedure(s), surgical service, surgeons and case type.

List of Operations (by Postoperative Disposition) SRO CASES BY DISPOSITION
This report will list completed cases for a selected date range sorted by postoperative disposition and by surgical specialty.

List of Operations (by Surgical Priority) SRO CASES BY PRIORITY
This report will list completed cases for a specified date range sorted by the surgical priority (elective, emergent, etc.). The patient name and SSN, date of operation, operative procedure, and surgical specialty will be displayed for each case.

List of Operations (by Surgical Specialty) SROPLIST1
This report contains general information for completed cases within a selected date range, sorted by surgical specialty. It includes procedure(s), surgical specialty, surgeons and case type.

List of Operations Included on Quarterly Report SROQ LIST OPS
This option generates a list of completed operations that are included in the totals displayed on the Quarterly Report. The report displays the data fields that are checked by the Quarterly Report.

List of Surgery Risk Assessments SROA ASSESSMENT LIST
This option is used to print the List of Surgery Risk Assessments. From this option, six different reports can be produced, (1) List of Incomplete Assessment, (2) List of Completed Assessments, (3) List of Transmitted Assessments, (4) List of All Major Surgical Cases, (5) List of All Surgical Cases and (6) List of Completed/Transmitted Assessments Missing Information.

List of Undictated Operations SRODCT1
This option provides a listing of all completed cases that do not have a date/time of dictation entered.

List of Unmerged Operation Notes SRSTRANS ERROR
This option displays all operation notes transcribed by the user having a heading that does not match up with an entry in the Surgery file.

List of Untranscribed Surgeon's Dictation SRSDDEL

Listing of untranscribed physician's dictation.

List of Unverified Surgery Case SROUNV
This option will generate a list of all completed surgery cases that have not had the procedure, diagnosis and complications verified.

M&M Verification Report SRO M&M VERIFICATION REPORT
This option produces the M&M Verification Report which may be useful for
(1) reviewing occurrences and their assignments to operations
(2) reviewing death unrelated/related assignments to operations

Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range who experienced intropeative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk assessed operations that are in a completed state but have not yet transmitted to the national database.

Variety #1: Report information is printed by patient, listing all operations for the patient that occurred during the selected date range, plus any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range and, if printed by specialty, may include operations performed by other specialties. For every operation that is listed, the intraoperative and postoperative occurrences are also listed. Also, the report includes information about whether the operation was unrelated or related to death and the risk assessment type and status (if assessed). The report may be printed for a selected list of surgical specialties.

Variety #2: Report information is printed by patient in a format like the first variety. This report lists all risk assessed operations that are in a completed state but have not yet transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some other operations that may or may not be risk assessed, and, if risk assessed, may have any risk assessment status (incomplete, complete, or transmitted). However, every patient listed on this report will have at least one operation with a risk assessment status of 'complete'.

Maintain Surgery Waiting List SROWAIT

This menu contains options to enter, edit and delete patients on the surgery waiting list. It also includes an option to print the list.

Make Operation Requests SROOPREQ
This option will be used to 'book' operations for a selected date. This request will in turn be scheduled for a specific operating room at a specific time on that date.

Make a Request for Concurrent Cases SRSREQCC
This option will be used to request concurrent operative procedures.

Make a Request from the Waiting List SRSWREQ
This option is used to 'book' a patient for surgery that has been entered on the waiting list. The operative procedure and specialty will be stuffed automatically.

Management Reports SR MANAGE REPORTS
This menu contains various management type reports used by the surgical service.

Management Reports SRO-CHIEF REPORTS
This menu contains various management reports to be generated by the Chief of Surgery.

Medications (Enter/Edit) SROANES MED
This option will be used to enter or edit medications given during the operative procedure.

Monthly Surgical Case Workload Report SROA MONTHLY WORKLOAD REPORT
This option generates the Monthly Surgical Case Workload Report which may be printed and/or transmitted to the NSQIP national database.

Morbidity & Mortality Reports SROMM
This option generates the Morbidity and Mortality reports to be used by the Chief of Surgery. This option includes the Mortality Report and Perioperative Occurrences Report.

Non-Cardiac Assessment Information (Enter/Edit) SROA ENTER/EDIT
This menu contains options used to enter and edit information related to individual risk assessments.

Non-O.R. Procedures SRONOP
This menu contains options related to non-O.R. procedures.

Non-O.R. Procedures (Enter/Edit) SRONOP-ENTER

This option will be used to enter, update, or delete information related to non-OR procedures.

Non-Operative Occurrences (Enter/Edit) SROCOMP
This option is used to enter or edit occurrences that are not related to surgical procedures.

Normal Daily Hours (Enter/Edit) SR NORMAL HOURS
This option is used to enter or edit the daily start and end times for each operating room. The information will be used to set up the start and end times, for operating room utilization, on a weekly basis.

Nurse Intraoperative Report SRCODING NURSE REPORT
This option is used by the coders to print the nurse intraoperative report for an operation. This report is not available for non-OR procedures.

Nurse Intraoperative Report SRONRPT
This option prints the Nurses Intraoperative Report which contains all the information required to be documented by the Nursing staff for this case.

Operating Room Information (Enter/Edit) SRO-ROOM
This option is used to enter or edit information pertinent to each operating room, including start and end times, and the cleaning time.

Operating Room Utilization (Enter/Edit) SR UTIL EDIT ROOM
This option is used to enter or edit start and end times for operating rooms on a selected date.

Operating Room Utilization Report SR OR UTL1
This report prints utilization information for a selected date range for all operating rooms or for a single operating room. The report displays the percent utilization, the number of cases, the total operation time and the time worked outside normal hours for each operating room individually and all operating rooms collectively.

The percent utilization is derived by dividing the total operation time for all operations (including total time patients were in OR, plus the cleanup time allowed for each case, plus one hour allowance for startup and shutdown daily for each OR that had at least one case) by the total OR functioning time as defined in the Surgery Utilization file. The quotient is then multiplied by 100.

Operation SROMEN-OP

This option is used to enter or edit information determined during the operative procedure.

Operation (Short Screen) SROMEN-OUT
This screen is designed for surgical procedures performed on outpatient or ambulatory patients with local anesthesia.

Operation Information SROMEN-OPINFO
This one page display allows you to quickly reference primary information for a given case. There are no editing capabilities in this option.

Operation Information (Enter/Edit) SROA OPERATION DATA
This option is used to enter or edit information related to the operation.

Operation Menu SROPER
This menu contains the various options used to enter and display information for a selected surgical case.

Operation Report SROSRPT
This option creates the Operation Report which will be merged with the transcription of the case to create the patient's operative record.

Operation Requests for a Day SROP REQ
This option will generate a list of requested operations for a specific date. There are two formats (long and short form) in which the requests may be printed.

Operation Startup SROMEN-START
This option is used to enter information prior to the actual start of the operation.

Operation/Procedure Report SRCODING OP REPORT
This option is used by the coders to print the operation report on an operation or the non-OR procedure report on a non-OR procedure.

Operative Risk Summary Data (Enter/Edit) SROA CARDIAC OPERATIVE RISK
This option is used to enter or edit operative risk summary data for the cardiac surgery risk assessments.

Outcome Information (Enter/Edit) SROA OUTCOMES
This option is used to enter or edit postoperative information including complication outcomes, discharge diagnosis, and postoperative length of stay.

Outpatient Encounters Not Transmitted to NPCD SRO PCE NOTRANS

Outpatient surgical and non-OR procedures that are filed as encounters in the Patient Care Encounters (PCE) package without an active, count clinic identified for each encounter are not transmitted to the National Patient Care Database (NPCD) as workload. This option may be used as a tool for identifying these encounters that represent uncounted workload so that corrective actions may be taken in the Surgery package to insure these procedures are associated with an active, count clinic. After corrections are made, these encounters may be re-filed with PCE to be transmitted to
NPCD.

This option provides functionality:
- To count and/or list surgical cases and non-OR procedures that have entries in PCE but have no matching entries in the OUTPATIENT ENCOUNTER file (#409.68) or have matching entries that are non-count encounters or encounters requiring action.
- To re-file with PCE the cases identified as having no matching entries in the OUTPATIENT ENCOUNTER file (#409.68) or having matching entries that are non-count encounters or encounters requiring action.

Both the report and the re-filing process may be run for OR surgical cases, non-OR procedures or both. The report and the re-filing process may be run for a specific specialty or for all specialties and may be run for a selected date range.

PCE Filing Status Report SRO PCE STATUS
This option provides a report of the PCE filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for OR surgical cases, non-OR procedures or both. Also, the report may be printed for all specialties or for a single specialty only.

This report is intended to be used a tool in the review of Surgery case information that is passed automatically to PCE. The report uses 5 status categories:
(1) FILED - This status indicates that case information has already been filed with PCE.
(2) QUEUED TO FILE - This status indicated the case is queued to file with PCE next time the Surgery nightly maintenance job runs.
(3) UPDATE QUEUED - This status indicates that information passed to PCE has been updated after the case was filed with PCE and PCE will be updated the next time the Surgery nightly maintenance job runs.
(4) NOT QUEUED - This status indicates the case is missing information required for filing with PCE.

(5) UNCERTAIN - If the UPDATES TO PCE site parameter is set to file outpatient cases only, this status indicates the IN/OUT-PATIENT STATUS field is null.

Two forms of the report are available, the long and the short. The long form uses a 132 column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, QUEUED TO FILE or UPDATE QUEUED the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT QUEUED or UNCERTAIN, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD codes for cases with a status of FILED, QUEUED TO FILE, and UPDATE QUEUED.

The short form uses an 80-column format and does not include surgeon/provider, attending, principal post-op diagnosis and CPT and ICD code information. The totals printed at the end will show only the total cases for each status.

Patient Demographics (Enter/Edit) SROA DEMOGRAPHICS
This option is used to enter, edit or review risk assessment patient demographic information such as patient movement dates, length of postoperative hospital stay, race, in/out-patient status and other information related to this surgical episode.

Perioperative Complications (Enter/Edit) SROA CARDIAC COMPLICATIONS
This option is used to enter or edit perioperative complication information for cardiac surgery risk assessments.

Perioperative Occurrences Menu SRO COMPLICATIONS MENU
This menu contains options used to enter, edit, and display perioperative occurrence information. It is only accessible to those users that hold the SROCOMP security key.

Person Field Restrictions Menu SROKEY MENU
This menu contains options used to maintain restrictions applied to "person" type fields in files. One or more keys may be entered so that only those who have at least one of them may be entered in a particular field.

Post Operation SROMEN-POST
This option is used to enter or edit information obtained after the operation.

Postoperative Occurrences (Enter/Edit) SRO POSTOP COMP
This option is used to enter or edit information related to postoperative occurrences.

Preoperative Information (Enter/Edit) SROA PREOP DATA
This option is used by the nurse reviewer to enter or edit preoperative assessment information.

Print 30 Day Follow-up Letters SROA REPRINT LETTERS
This option is used to print 30 day follow up letters. When using this option, letters can be printed for a specific assessment or all assessments within a selected date range.

Print Blood Product Verification Audit Log SR BLOOD PRODUCT VERIFY AUDIT
This option is used to print the KERNEL audit log for the Surgery option, [SR BLOOD PRODUCT VERIFICATION].

Print Surgery Waiting List SRSWL2
This option generates the long form surgery waiting list for the surgical service(s) selected.

Print a Surgery Risk Assessment SROA PRINT ASSESSMENT
This option is used to print an entire Surgery Risk Assessment for an individual patient.

Procedure Report (Non-O.R.) SR NON-OR REPORT
This option produces a non-O.R. procedure report displaying information about the case selected.

Purge Utilization Information SR PURGE UTILIZATION
This option is used to purge utilization information for a selected date range. After selecting a starting date, you may purge all utilization information for dates prior to, and including, that starting date.

Quarterly Report - Surgical Service SRO QUARTERLY REPORT
This option will generate the quarterly report to be submitted to the Surgical Service, Central Office. The option also provides the flexibility to print the summary report for selected date ranges.

Quarterly Report Menu SROQ MENU
This menu contains the option to generate the Quarterly Report and the associated options that may be helpful in validating information on the Quarterly Report.

Queue Assessment Transmissions SROA TRANSMIT ASSESSMENTS
This option may be used to manually queue the NSQIP transmission process to run at a selected time. The NSQIP transmission process is a part of the nightly maintenance and cleanup process.

Remove Restrictions on 'Person' Fields SROKEY REMOVE
This option is used to delete keys that have been assigned to a field to restrict entries. Using this option you may delete one specific key, or all keys.

Report of CPT Coding Accuracy SR CPT ACCURACY
This report prints cases sorted by the CPT code used for principal and other operative procedures. It is designed as a tool to check the accuracy of coding procedures.

Report of Cancellation Rates SROCRAT
This option generates the Report of Cancellation Rates. The report can be printed for an individual Surgical Specialty, or the entire medical center. The report shows the following 3 rates:
1) The cancellation percentage of all scheduled cases, calculated as follows:

(TOTAL CANCELS / TOTAL SCHEDULED) x 100

2) The avoidable cancellation percentage of all scheduled cases, calculated as follows:

(TOTAL AVOIDABLE CANCELS / TOTAL SCHEDULED) x 100

3) The avoidable cancellation percentage of all cancelled cases, calculated as follows:

(TOTAL AVOIDABLE CANCELS / TOTAL CANCELS) x 100

Report of Cancellations SROCAN
This report is designed to provide information for cases that have been scheduled and cancelled.

Report of Cases Without Specimens SROSPEC
This report lists all completed cases in which there were no specimens taken from the operative site. It can be printed for an individual surgical specialty if desired.

Report of Daily Operating Room Activity SROPACT

This report will provide a list of cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

Report of Delay Reasons SROREAS
This option is used to print the Report of Delay Reasons. This report will display the total number of times each reason was used for the date range selected. It can be sorted by surgical specialty or displayed for an individual surgical specialty.

Report of Delay Time SRO DELAY TIME
This report will provide the total amount of delay time for each delay reason over a specified range of dates.

Report of Delayed Operations SRODELA
This report will display all cases that have been delayed. It will display both the delay cause and delay time.

Report of Missing Quarterly Report Data SROQ MISSING DATA
This option generates a list of surgical cases performed within the selected date range that are missing information used by the Quarterly Report. This report includes surgical cases with an entry in the TIME PAT IN OR field and does not include aborted cases.

Report of Non-O.R. Procedures SRONOR
This report will chronologically list Non-OR Procedures sorted by Medical Specialty, by provider or by location.

Report of Non-O.R. Procedures SRONOR-CODERS
This report will chronologically list Non-OR Procedures sorted by Medical Specialty, by provider or by location.

Report of Normal Operating Room Hours SR OR HOURS
This report outputs the start time and the end time of the normal working hours for all operating rooms or for the selected operating room for each date within the specified date range. The total time of the normal working day is displayed for each operating room for each date.

Report of Returns to Surgery SRORET
This option generates a report listing information related to cases that have related surgical procedures within 30 days of the date of the operation.

Report of Surgical Priorities SRO SURGICAL PRIORITY

This report provides the total number of surgical cases for each Surgical Priority (i.e. Elective, Emergent, Urgent). It can be sorted by Surgical Specialty and printed for a specific specialty.

Report of Unscheduled Admissions to ICU SROICU
This report will list all unscheduled admissions to the ICU based on the requested (expected) postoperative care and actual postoperative disposition.

Request Operations SROREQ
This menu contains the various options used to make, delete, update and display requested operations.

Requests by Ward SROWRQ
This option will print request information for all wards, or a specific ward.

Reschedule or Update a Scheduled Operation SRSCHUP
This option will be used to change the date, time or operating room for which a case is scheduled. It may also be used to update information entered when the case was requested or scheduled.

Resource Data SROA CARDIAC RESOURCE
This option is used to enter, edit or review risk assessment cardiac patient demographic information such as hospital admission and discharge dates and other information related to this surgical episode.

Review Request Information SROREQV
This option is used to review or edit request information for an individual case.

Schedule Anesthesia Personnel SRSCHDA
This option is used to schedule anesthesia personnel for surgery cases.

Schedule Operations SROSCHOP
This menu contains the various options used to schedule, update, cancel and display scheduled operations.

Schedule Requested Operations SRSCHD1
This option will be used to schedule cases that have been previously 'booked' for the selected date.

Schedule Unrequested Concurrent Cases SRSCHDC
This option is used to schedule concurrent cases that have not been requested.

Schedule Unrequested Operations SROSRES

This option will be used to schedule cases that have not been previously 'booked'. You will be asked to enter some initial information regarding this case as well as the operating room and date/time for it to be scheduled.

Schedule of Operations SROSCH
This option generates the Operating Room Schedule to be used by the OR nurses, surgeons and anesthetists.

Scrub Nurse Staffing Report SROSNR
This report contains general information for completed cases, sorted by the Operating Room Scrub Nurse.

Surgeon Staffing Report SROSUR
This report prints completed cases, sorted by the surgeon and his role (i.e. attending, first assistant) for each case. It includes the procedure, diagnosis and operation date/time.

Surgeon's Verification of Diagnosis & Procedures SROVER
This option is used to verify that the procedure(s), diagnosis and complications are correct for the case. It is intended for use by the Surgeon, not the OR nurses.

Surgeons' Dictation Menu SR DICTATION
This menu contains options associated with the Surgeons' Dictation of Operation Notes.

Surgery Interface Management Menu SRHL INTERFACE
This menu contains options that allow the user to set up certain interface parameters that control the processing of HL7 messages. The interface adheres to the Health Level 7 (HL7) protocol and forms the basis for the exchange of health care information between the VistA Surgery package and any ancillary system.

Surgery Menu SROMENU
This is the main menu for the Surgery package.

Surgery Nightly Cleanup and Updates SRTASK-NIGHT
This option is queued to run daily. It will initiate a number of background tasks to cleanup the surgery database and update all appropriate information. Among the tasks done are calculation of average procedure times, cleanup of outstanding requests, update expected start and end times for operating rooms and surgical specialties, and locking cases.

Surgery Package Management Menu SRO PACKAGE MANAGEMENT
This menu contains options used to manage the Surgery package. It includes options to maintain site configurable information within the package.

Surgery Reports SRORPTS
This menu contains the various reports used in the Surgery package. Those reports that are restricted to the Chief of Surgery will not appear within this menu.

Surgery Request SR SURGERY REQUEST
This protocol allows the entry and editing of operation requests through OE/RR.

Surgery Risk Assessment - Site Update Server SROASITE
This server is used to update Surgery Risk Assessments that have been successfully transmitted to the Surgery Risk Assessment National Database at the Chicago ISC. This server updates two fields, ASSESSMENT STATUS (#235) and DATE TRANSMITTED (#260). These fields are updated at the site from the message sent by the database servers at Chicago only if the messages were processed successfully into the national database.

Surgery Risk Assessment Menu SROA RISK ASSESSMENT
This menu contains options used to create, maintain, and transmit surgery risk assessments.

Surgery Site Parameters (Enter/Edit) SROPARAM
This option is used to create or update local site parameters for the Surgery package.

Surgery Staffing Reports SR STAFFING REPORTS
This menu contains surgical staffing reports for surgeons and nurses.

Surgery Transcription Menu SRSTRANS MENU
This menu contains the various options used in association with the transcription of surgery operation notes.

Surgery Utilization Menu SR OR UTIL
This menu contains various Operating Room Utilization reports.

Surgical Nurse Staffing Report SRONSR
This option generates the Surgical Nurse Staffing Report for a specified date range.

Surgical Staff SROMEN-STAFF
This option is used to enter the staff (surgeons, nurses, anesthetists) for a given case. It includes everyone in the operating room for this case.

Table Download SRHL DOWNLOAD SET OF CODES

This option downloads the SURGERY file (#130) set of codes to the Automated Anesthesia Information System (AAIS). This process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Tissue Examination Report SROTRPT

This option is used to generate the Tissue Examination Report which contains culture and specimens sent to the laboratory.

Transcribe Surgeon's Dictation (FileMan) SRSTRAN

This option is used to transcribe the surgeon's dictation. At present, it utilizes the cumbersome word processor of VA FileMan.

Transmit Transcribed Operation Notes SRSEND

This option is used by the transcriptionist to download a batch of transcribed operation notes from a word processor or personal computer to the **V*IST*A** system. The operation notes will then be merged with the proper case in the Surgery file.

This option requires that the text be in the format shown below.

Each new case must begin with a heading beginning with an '@' followed by the case number, date of operation, and the patient's first letter of his last name followed by the last four digits in his SSN. The heading will look similar to this:

@233/8 12 88/G2078

Please note that there must be a slash (/) separating the case number (in this case 233), the date (8 12 88) and the patient identifier (G2078).

Each new note must have a new header. At the end of the entire text, there will be a line of characters representing the end of the file. The characters are @###. When the routine hits a line starting with the characters @###, it is finished. The example below may help in explaining the format.

```
@233/8 12 88/M2078
An appendectomy was done on Larry Mondello on August 12th, 1988.
Because of ... There were no complications as a result of this surgery.
@234/8 12 88/D4511
Mr. Sam Drucker had chronic cholecystitis ...
```

... Mr. Drucker was then admitted to the MICU.
@###

In this example there are two cases (233 and 234) which will be transmitted to the **V*IST*A** system.

Undictated Operations SRODICT
This option will list all of your cases that are complete, but have not been dictated.

Unlock a Case for Editing SRO-UNLOCK
This option is used by the Chief of Surgery, or a person designated by him or her to unlock a case that has been completed and locked.

Update 1-Liner Case SROA ONE-LINER UPDATE
This option may be used to enter missing data for the 1-liner cases (major cases marked for exclusion from assessment, minor cases and cardiac assessed cases that transmit to the NSQIP database as a single line or two of data). Cases edited with this option will be queued for transmission to the NSQIP database at Chicago.

Update Assessment Completed/Transmitted in Error SROA TRANSMITTED IN ERROR
This option is used to update the status of a completed or transmitted assessment which has been entered in error. The status will change from 'COMPLETED' or 'TRANSMITTED' to 'INCOMPLETE' so that editing may occur.

Update Assessment Status to 'COMPLETE' SROA COMPLETE ASSESSMENT
This option is used to update the status of a risk assessment entry from 'INCOMPLETE' to 'COMPLETE'. Only completed assessments can be transmitted.

Update Cancellation Reason SRSUPC
This option is used to update the cancellation date and reason previously entered for a selected surgical case.

Update Cancelled Case SRO UPDATE CANCELLED CASE
This option allows the Chief of Surgery to update information on a cancelled case.

Update Interface Parameter Field SRHL PARAMETER
This option may be used to edit the site parameter that determines which Surgery HL7 interface will be used, the interface compatible with **V*IST*A** HL7 v1.6 or the older one compatible with **V*IST*A** HL7 v1.5.

If applications communicating with the Surgery HL7 interface must use the interface designed for use with HL7 v1.5, enter YES. Otherwise, enter NO or leave this field blank.

Update O.R. Schedule Devices SR UPDATE SCHEDULE DEVICE
This option is used to update the list of O.R. Schedule Devices in the Surgery Site Parameters file (133).

Update Operations as Unrelated/Related to Death SRO DEATH RELATED
This option is used to update the status of operations performed within 90 days prior to death as unrelated or related to death, allowing comments to be entered to further document the review of death.

Update Site Configurable Files SR UPDATE FILES
This option is used to add, edit, or delete information in the site configurable files contained within the Surgery package.

File entries that are not to be used should be made inactive and should not be deleted from the file.

Update Staff Surgeon Information SROSTAFF
This option allows the designation of a user as a staff surgeon by assigning the security key 'SR STAFF SURGEON'. The Annual Report of Surgical Procedures counts cases performed by holders of this security key as performed by 'STAFF'. All other cases are counted as performed by 'RESIDENT'.

Update Status of Returns Within 30 Days SRO UPDATE RETURNS
This option is used to update the status of Returns to Surgery within 30 days of a surgical case.

Update/Verify Procedure/Diagnosis Codes SRCODING EDIT
This option is used to edit and/or verify the CPT and ICD9 codes for an operation or non-OR procedure.

View Patient Perioperative Occurrences SROMEN-M&M
This option displays perioperative occurrence information for a given case.

Wound Classification Report SROWC
This option generates a report for the selected date range showing the total number of surgical cases with each of the various wound classifications broken down by surgical service.

Exported Menu Structure

There are two top level menus exported with the Surgery package.

Surgery Menu [SROMENU] - This menu should be given to all users of the Surgery package.

Surgery Transcription Menu [SRSTRANS MENU] - This menu should be given to any person responsible for the transcription of the surgeon's operative notes. This may include the secretarial staff and surgeons.

Routines

The following is the list of routines used in the Surgery package. This list excludes all initialization routines, protocol installation routines and routines exported with patches that performed a one time function. The first line of each routine contains a brief description of the general function of the routine. Use the Kernel option XU FIRST LINE PRINT *(First Line Routine Print)* to print a list of just the first line of each routine in the SR- namespace.

SRBLOOD SRCUSS SRCUSS0 SRCUSS1 SRCUSS2 SRCUSS3 SRCUSS4 SRCUSS5
SRHLDW SRHLDW1 SRHLMFN SRHLOORU SRHLORU SRHLQRY SRHLSCRN SRHLU
SRHLUI SRHLUO SRHLUO1 SRHLUO2 SRHLUO3 SRHLUO4 SRHLUO4C SRHLVOOR
SRHLVORU SRHLVQRY SRHLVU SRHLVUI SRHLVUI2 SRHLVUO SRHLVUO1 SRHLVUO2
SRHLVUO4 SRHLVZIU SRHLVZQR SRHLVZSQ SRHLXTMP SRHLZIU SRHLZQR SRO1L
SRO1L1 SROA30 SROABCH SROAC SROAC1 SROAC2 SROACAR SROACAT
SROACC SROACC0 SROACC1 SROACC2 SROACC3 SROACC4 SROACC5 SROACC6
SROACCM SROACCR SROACCT SROACL1 SROACLN SROACMP SROACMP1 SROACOM
SROACOP SROACPM SROACR1 SROACRC SROACS SROACTH SROADEL SROADOC
SROADOC1 SROAERR SROAEX SROAL1 SROAL11 SROAL2 SROAL21 SROALAB
SROALC SROALCP SROALCS SROALCSP SROALDP SROALEN SROALESS SROALET
SROALL SROALLP SROALLS SROALLSP SROALM SROALN1 SROALN2 SROALN3
SROALNO SROALOG SROALSS SROALSSP SROALST SROALSTP SROALT SROALTP
SROALTS SROALTSP SROAMAN SROAMEAS SROAMIS SROAMIS1 SROANEW SROANIN
SROANP SROANP1 SROANT SROANTP SROANTS SROANTSP SROAO SROAOP
SROAOP1 SROAOP2 SROAOPS SROAOSET SROAOTH SROAPAS SROAPC SROAPCA
SROAPCA0 SROAPCA1 SROAPCA2 SROAPCA3 SROAPIMS SROAPM SROAPR1A SROAPR2
SROAPRE SROAPRE1 SROAPRE2 SROAPRT1 SROAPRT2 SROAPRT3 SROAPRT4 SROAPRT5
SROAPRT6 SROAPRT7 SROAPS1 SROAPS2 SROAR SROAR1 SROAR2 SROARET
SROARPT SROARPT0 SROARPT1 SROARPT2 SROASITE SROASS SROASS1 SROASSE
SROASSP SROASWAP SROASWP SROASWP0 SROASWP1 SROASWP2 SROASWP3 SROASWPD
SROAT0P SROAT0T SROAT1P SROAT1T SROAT2P SROAT2T SROATCM SROATCM1
SROATCM2 SROATM1 SROATM2 SROATM3 SROATM4 SROATMIT SROATMNO SROATT
SROATT0 SROATT1 SROATT2 SROAUTL SROAUTL0 SROAUTL1 SROAUTL2 SROAUTL3
SROAUTL4 SROAUTLC SROAWL SROAWL1 SROBLOD SROBTCH SROCAN SROCAN0
SROCANUP SROCASE SROCCAT SROCHDD SROCMP SROCMP1 SROCMP2 SROCMPD
SROCMPED SROCMPL SROCMPS SROCNR SROCNR1 SROCNR2 SROCODE SROCOM
SROCOMP SROCON SROCON1 SROCOND SROCPT SROCRAT SRODATE SRODCT1
SRODELA SRODEV SRODICT SRODIS SRODIS0 SRODLA1 SRODLA2 SRODLAY
SRODLT SRODLT0 SRODLT1 SRODLT2 SRODPT SRODTH SROERR SROERR0
SROERR1 SROERR2 SROERRPO SROFILE SROFLD SROGTSR SROICU SROICU1
SROICU2 SROINQ SROIRR SROKEY SROKEY1 SROKRET SROLOCK SROMED
SROMENU SROMOD SROMOR SROMORT SRONAN SRONAN1 SRONASS SRONBCH
SRONEW SRONIN SRONIN1 SRONIN2 SRONIN3 SRONIN4 SRONIN5 SRONIN6
SRONITE SRONON SRONON0 SRONON1 SRONOP SRONOP1 SRONOR SRONOR1
SRONOR2 SRONOR3 SRONOR4 SRONOR5 SRONOR6 SRONOR7 SRONOR8 SRONRN1
SRONRN2 SRONRN3 SRONRN4 SRONRN5 SRONRNF SRONRPT SRONRPT0 SRONRPT1
SRONRPT2 SRONRPT3 SRONUR SRONUR1 SRONUR2 SRONXR SROOPRM SROOPRM1
SROP SROP1 SROPAC0 SROPAC1 SROPACT SROPAT SROPCE SROPCE0
SROPCE0A SROPCE0B SROPCE1 SROPCEU SROPCEU0 SROPCEX SROPDEL SROPER
SROPLIS SROPLIST SROPLST1 SROPLSTS SROPOST SROPOST0 SROPOST1 SROPOST2
SROPPC SROPR01 SROPR02 SROPR03 SROPRE SROPRE0 SROPREQ SROPRI
SROPRI1 SROPRI2 SROPRIN SROPRIO SROPRIT SROPROC SROPRPT SROPRPT1
SROPRPT2 SROPRPT3 SROPRPT4 SROPS SROQ SROQ0 SROQ0A SROQ1
SROQ1A SROQ2 SROQADM SROQD SROQD0 SROQD1 SROQIDP SROQIDP0
SROQL SROQM SROQM0 SROQM1 SROQN SROQT SROR SRORAT1
SRORAT2 SRORATA SRORATP SRORATS SROREA SROREA1 SROREA2 SROREAS
SROREQ SROREQ1 SROREQ2 SROREQ3 SROREQ4 SRORES T SRORESV SRORET
SRORHRS SRORHRS0 SRORIN SRORTRN SRORUT SRORUT0 SRORUT1 SRORUT2
SROSCH SROSCH1 SROSCH2 SROSNR SROSNR1 SROSNR2 SROSPC1 SROSPEC
SROSPLG SROSPLG1 SROSPLG2 SROSPSS SROSRPT SROSRPT0 SROSRPT1 SROSRPT2

```
SROSTAFF  SROSTOP   SROSUR    SROSUR1   SROSUR2   SROTHER   SROTRIG   SROTRPT
SROTRPT0  SROUNV    SROUNV1   SROUNV2   SROUTED   SROUTIN   SROUTL    SROUTL0
SROUTR1   SROUTRN   SROUTUP   SROVAR    SROVER    SROVER1   SROVER2   SROVER3
SROWC     SROWC1    SROWC2    SROWC3    SROWL     SROWL0    SROWRQ    SROWRQ1
SROXPR    SROXR1    SROXR2    SROXR4    SROXREF   SROXRET   SRSAVG    SRSAVL
SRSAVL1   SRSBD1    SRSBDEL   SRSBLOK   SRSBOUT   SRSBTCH   SRSCAN    SRSCAN0
SRSCAN1   SRSCAN2   SRSCD     SRSCDS    SRSCDS1   SRSCDW    SRSCDW1   SRSCG
SRSCHAP   SRSCHC    SRSCHC1   SRSCHC2   SRSCHCA   SRSCHCC   SRSCHD    SRSCHD1
SRSCHD2   SRSCHDA   SRSCHDC   SRSCHK    SRSCHOR   SRSCHUN   SRSCHUN1  SRSCHUP
SRSCONR   SRSCPT    SRSCPT1   SRSCPT2   SRSCRAP   SRSDIS1   SRSDISP   SRSDT
SRSEND    SRSGRPH   SRSIND    SRSKILL   SRSKILL1  SRSKILL2  SRSLOOK   SRSLOOK1
SRSMREQ   SRSPUT0   SRSPUT1   SRSPUT2   SRSRBS    SRSRBS1   SRSRBW    SRSRBW1
SRSREQ    SRSREQUT  SRSRQST   SRSRQST1  SRSTIME   SRSTR     SRSTRAN   SRSUP1
SRSUPC    SRSUPRG   SRSUPRQ   SRSUTIN   SRSUTL    SRSUTL2   SRSWL     SRSWL1
SRSWL10   SRSWL11   SRSWL12   SRSWL13   SRSWL14   SRSWL15   SRSWL2    SRSWL3
SRSWL4    SRSWL5    SRSWL6    SRSWL7    SRSWL8    SRSWL9    SRSWLST   SRSWREQ

     536 routines
```

Callable Routines

The following routines have callable entry points and are available to other packages through Data Base Integration Agreements (DBIAs).

SROGTSR
Entry point: **GET(SRGY,SRDFN)**
This call returns an array containing a list of the patient's operations.
Parameter list: SRGY - the name of the array
SRDFN - the patient's IEN in the PATIENT file (#2)

SROPRPT
Entry point: **SROPRPT**
This call displays the operation report.
Input variable: The variable SRTN (which identifies the surgical case) may be defined before making the call. If the variable SRTN is not defined when the call is made, the user will be prompted to select a patient and operation.

SROPS
Entry point: **SROPS**
This call provides patient lookup and operation selection.

SROSPLG
Entry point: **SROSPLG**
This call was designed specifically for the surgical pathology module of the LABORATORY package.
Input variables: LRDFN - the patient's IEN in the LAB DATA file (#63)
LRSS - the laboratory subscript for surgical pathology ("SP")
LRI - the inverse date subscript the LAB DATA file (#63)

Cross References

SURGERY (130)

AA This MUMPS cross reference on the VISIT field (#.015) maintains the dependency count for this visit in the VISIT file.

AC The AC cross reference on the DATE OF OPERATION field (#.09) is used to sort entries by date of operation for reporting purposes.

ACAN The ACAN cross reference on the CANCEL REASON field (#18) functions to stuff the CANCELLATION AVOIDABLE field with the default as defined in the SURGERY CANCELLATION REASON file for the CANCEL REASON entered. It also stuffs the CANCELLED BY field with the user if that field is not already defined.

ACPT This MUMPS cross reference on the PRINCIPAL PROCEDURE CODE field (#27) provides for updating CPT modifiers for the principal procedure code. CPT modifiers for the PRINCIPAL PROCEDURE CODE field (#27) are stored in the PRIN. PROCEDURE CPT MODIFIER field (#.01) of the PRIN. PROCEDURE CPT MODIFIER multiple field (#28) in SURGERY file (#130).

After selecting a CPT code, this cross reference prompts the user for a CPT modifier. If a CPT modifier was entered concatenated with a hyphen to the CPT code, this CPT modifier is displayed as a default modifier. Upon entering a CPT modifier, the user is prompted for another CPT modifier until the user makes a null entry. CPT modifier input is controlled by the input transform on the PRIN. PROCEDURE CPT MODIFIER field (#28). At the CPT modifier prompt, the user may to enter a question mark (?) to see a list of CPT modifiers already entered and a list of acceptable CPT modifiers to choose from. If the user selects a modifier already entered, the user may change or delete the modifier. If a user enters a new CPT code, replacing a previously entered CPT code, KILL logic on the ACPT cross reference deletes any previously entered CPT modifiers for the old CPT code before the SET logic prompts the user to enter CPT modifiers for the new CPT code.

ADIC The ADIC cross reference on the TIME OPERATION ENDS field (#.23) is used to sort cases that are finished but for which the surgeon's dictation has not yet been entered.

ADT The ADT cross reference on the DATE OF OPERATION field (#.09) uses the inverse date/time format to sort and to display cases by reverse chronological order.

AE This MUMPS cross reference on the ESTIMATE OF MORTALITY field (#364) updates the Date/Time of Estimate of Operative Mortality field (#364.1) when the Physician's Preoperative Estimate of Operative Mortality field (#364) is edited.

AF The AF cross reference on the ANES CARE START TIME field (#.21) calls IV^SROXR1 if IV orders are to be cancelled upon admission to surgery.

AH This MUMPS cross reference on the TIME PAT OUT OR field (#.232) moves the OTHER PREOP DIAGNOSIS information into the OTHER POSTOP DIAGS sub-file (#130.18) when the TIME PAT OUT OR is entered.

AI This MUMPS cross reference on the REQ POSTOP CARE field (#.43) stuffs the requested post-operative care entry into the PACU DISPOSITION field (#.79).

AL This MUMPS cross reference on the LOCK CASE field (#24) uses reverse set and kill logic to flag cases that have been locked, then unlocked. The cross reference for the case is set when the field is deleted and is killed when input is made into the field.

AM1 This MUMPS cross reference on the TIME PAT OUT OR field (#.232) is responsible for removing the AMM cross reference for the case and for updating the scheduling display graph. In addition, if the case is a requested case, the AR cross reference is removed if it still exists.

AM2 This MUMPS cross reference on the SCHEDULED START TIME field (#10) resets the AMM cross reference for the case when the scheduled start time is edited.

AM3 This MUMPS cross reference on the OPERATING ROOM field (#.02) updates the AMM cross reference when the OPERATING ROOM is edited if the case has been scheduled.

AMM This MUMPS cross reference on the SCHEDULED END TIME field (#11) sets the AMM cross reference for the case if the operating room and the scheduled start time are defined.

AMS This MUMPS cross reference on the MANDIBULAR SPACE field (#901.2) is used to update the AIRWAY INDEX field (#901) when the MANDIBULAR SPACE field is edited.

AND This MUMPS cross reference on the TIME PROCEDURE ENDED field (#122) updates the ANES CARE END TIME field (#.24) if the non-O.R. procedure is assigned to the Anesthesiology medical specialty.

ANES This MUMPS cross reference on the PRINC ANESTHETIST field (#.31) updates the ANESTHETIST CATEGORY field (#103) when a principal anesthetist is entered.

ANON This MUMPS cross reference on the OCCURRENCE/NO PROCEDURE field (#54) is used to flag cases that have non-operative occurrences entered.

ANOR This MUMPS cross reference on the NON-OR PROCEDURE field (#118) is used to flag cases as non-O.R. procedures.

AOP This MUMPS cross reference is used to update the AIRWAY INDEX field (#901) when the ORAL-PHARYNGEAL CLASS field (#901.1) is edited.

AOR This MUMPS cross reference on the OPERATING ROOM field (#.02) is used in various reports when sorting by operating room.

AP This cross reference on the CASE SCHEDULE TYPE field (#.035) stuffs the current date/time into the Date/Time of Cardiac Surgical Priority field (#414.1).

AP1 This MUMPS cross reference on the CARDIAC SURGICAL PRIORITY field (#414) updates the Date/Time of Cardiac Surgical Priority field (#414.1) when the Cardiac Surgical Priority field is edited.

APCE1 This MUMPS cross reference on the SURGEON field (#.14) maintains the APCE cross reference nodes used in updating PCE.

APCE10 This MUMPS cross reference on the TIME PROCEDURE BEGAN field (#121) maintains the APCE cross reference nodes used in updating PCE.

APCE11 This MUMPS cross reference on the TIME PROCEDURE ENDED field (#122) maintains the APCE cross reference nodes used in updating PCE.

APCE12 This MUMPS cross reference on the PROVIDER field (#123) maintains the APCE cross reference nodes used in updating PCE.

APCE13 This MUMPS cross reference on the ATTEND PROVIDER field (#124) maintains the APCE cross reference nodes used in updating PCE.

APCE14 This MUMPS cross reference on the OTHER PROCEDURE CPT CODE field (#3) in the OTHER PROCEDURES multiple field (#.42, sub-file #130.16) maintains the APCE cross reference nodes used in updating PCE.

APCE15 This MUMPS cross reference on the ICD DIAGNOSIS CODE field (#3) in the OTHER POSTOP DIAGS multiple field (#.74, sub-file #130.18) maintains the APCE cross reference nodes used in updating PCE.

APCE16 This MUMPS cross reference on the SERVICE CONNECTED field (#.016) maintains the APCE cross reference nodes used in updating PCE.

APCE17 This MUMPS cross reference on the AGENT ORANGE EXPOSURE field (#.017) maintains the APCE cross reference nodes used in updating PCE.

APCE18 This MUMPS cross reference on the IONIZING RADIATION EXPOSURE field (#.018) maintains the APCE cross reference nodes used in updating PCE.

APCE19 This MUMPS cross reference on the ENVIRONMENTAL CONTAMINANTS field (#.019) maintains the APCE cross reference nodes used in updating PCE.

APCE2 This MUMPS cross reference on the PRINCIPAL PROCEDURE CODE field (#27) maintains the APCE cross reference nodes used in updating PCE.

APCE20 This MUMPS cross reference on the OPERATING ROOM field (#.02) maintains the APCE cross reference nodes used in updating PCE.

APCE21 This MUMPS cross reference on the ASSOCIATED CLINIC field (#.021) maintains the APCE cross reference nodes used in updating the Patient Care Encounters (PCE) package. The format for the resulting cross reference node is as follows:

^SRF("APCE",IEN) = Pointer to VISIT file (#9000010)

APCE3 This MUMPS cross reference on the SURGERY SPECIALTY field (#.04) maintains the APCE cross reference nodes used in updating PCE.

APCE4 This MUMPS cross reference on the ATTEND SURG field (#.164) maintains the APCE cross reference nodes used in updating PCE.

APCE5 This MUMPS cross reference on the IN/OUT-PATIENT STATUS field (#.011) maintains the APCE cross reference nodes used in updating PCE.

APCE6 This MUMPS cross reference on the TIME PAT IN OR field (#.205) maintains the APCE cross reference nodes used in updating PCE.

APCE7 This MUMPS cross reference on the TIME PAT OUT OR field (#.232) maintains the APCE cross reference nodes used in updating PCE.

APCE8 This MUMPS cross reference on the PRIN DIAGNOSIS CODE field (#66) maintains the APCE cross reference nodes used in updating PCE.

APCE9 This MUMPS cross reference on the NON-OR LOCATION (#119) maintains the APCE cross reference nodes used in updating PCE.

AQ This MUMPS cross reference on the TIME PAT OUT OR field (#.232) is used by the transmission process to the NSQIP national database.

AQ1 This MUMPS cross reference on the READY TO TRANSMIT? Field (#905) updates the AQ cross reference list of cases that are ready to be transmitted to the NSQIP national database.

AR This MUMPS cross reference on the DATE OF OPERATION field (#.09) is used to sort and display requested cases. This cross reference is created when a case is requested or when the request date is changed. Upon scheduling the request, the AR cross reference for the case is deleted.

ARET This MUMPS cross reference on the PATIENT field (#.01) removes returns to surgery that are defined for other cases when a case is deleted. In addition, the ARET cross reference includes logic to remove AL and AUD nodes (on case deletion) that may exist because of the reverse set and kill logic on the AL and AUD cross references.

ARS This MUMPS cross reference on the ASSESSMENT STATUS field (#235) is used to determine the assessment status of non-cardiac and cardiac assessments.

ASP — This MUMPS cross reference on the SURGERY SPECIALTY field (#.04) is used by various reports to sort by the surgical specialty and within surgical specialty by date of operation.

ASP1 — This MUMPS cross reference on the DATE OF OPERATION field (#.09) updates the ASP and the AOR cross references when the date of operation is changed.

ASR — This MUMPS cross reference on the SURGEON field (#.14) is used to update the STAFF/RESIDENT field (#101) when a surgeon is entered.

AST — This MUMPS cross reference on the TIME PROCEDURE BEGAN field (#121) updates the ANES CARE START TIME field (#.21) if the non-O.R. procedures is assigned to the Anesthesiology medical specialty.

AUD — This MUMPS cross reference on the DATE/TIME OF DICTATION field (#15) is used for listing undictated cases. The set and kill statements for this cross reference use reverse logic. The AUD cross reference for a case is removed when entry is made into the DATE/TIME OF DICTATION field and it is set when the entry is deleted.

AUD1 — This MUMPS cross reference on the TIME PAT OUT OR field (#.232) sets the AUD cross reference for the case when the TIME PAT OUT OR field is entered.

AV — This regular cross reference on the VISIT field (#.015) is used for sorting.

B — The B cross reference on the PATIENT field is used by VA FileMan to lookup entries.

Trigger-Type Cross References:

TIME PAT IN OR (#.205)
This trigger updates the DATE OF OPERATION field (#.09) with the date/time the patient went into the operating room.

PRINCIPAL PRE-OP DIAGNOSIS (#32)
This trigger stuffs the PRINCIPAL POST-OP DIAGNOSIS field (#34) with the PRINCIPAL PRE-OP DIAGNOSIS.

DATE OF PROCEDURE (#120)

This trigger updates the DATE OF OPERATION field (#.09) when the DATE OF PROCEDURE is entered or edited. The DATE OF PROCEDURE field is used with non-O.R. procedures, and the DATE OF OPERATION field is updated to assist in sorting cases for reports.

Cross References on Sub-Files:

The B cross references in the sub-files within the SURGERY file are created by VA FileMan and are used for lookups within the sub-files.

PROSTHESIS INSTALLED (130.01)

AC The AC cross reference on the PROSTHESIS ITEM field of the PROSTHESIS INSTALLED multiple stuffs the default information stored in the PROSTHESIS file (131.9).

ACPT1 This MUMPS cross reference provides for updating CPT modifiers for other procedure CPT codes. CPT modifiers for the OTHER PROCEDURE CPT CODE field (#3) of the OTHER PROCEDURES multiple field (#.42) in SURGERY file (#130) are stored in the OTHER PROCEDURE CPT MODIFIER field (#.01) of the OTHER PROCEDURE CPT MODIFIER multiple field (#4) of the OTHER PROCEDURES multiple field (#.42).

After selecting a CPT code, this cross reference prompts the user for a CPT modifier. If a CPT modifier was entered concatenated with a hyphen to the CPT code, this CPT modifier is displayed as a default modifier. Upon entering a CPT modifier, the user is prompted for another CPT modifier until the user makes a null entry. CPT modifier input is controlled by the input transform on the OTHER PROCEDURE CPT MODIFIER field (#.01 of sub-file #130.164). At the CPT modifier prompt, the user may enter a question mark (?) to see a list of CPT modifiers already entered and a list of acceptable CPT modifiers to choose from. If the user selects a modifier already entered, the user may change or delete the modifier. If a user enters a new CPT code, replacing a previously entered CPT code, KILL logic on the ACPT1 cross reference deletes any previously entered CPT modifiers for the old CPT code before the SET logic prompts the user to enter CPT modifiers for the new CPT code.

Person Field Restriction (131)

B The B cross reference on the FIELD IDENTIFIER field (#.01) was created by VA FileMan and is used for lookups.

Cross References on Sub-Files:

KEYS (131.03)

AX This MUMPS cross reference on the KEYS field (#.01) is used when determining whether a "person" type field is restricted by one or more keys.

SURGERY TRANSPORTATION DEVICES (131.01)

B The B cross reference on the NAME field was created by VA FileMan and is used in doing lookups.

C The C cross reference on the CODE field (#1) is used for doing lookups.

OPERATION TIMES (131.25)

B The B cross reference on the SURGICAL SPECIALTY field (#.01) was created by VA FileMan and is used for lookups.

SURGERY DISPOSITION (131.6)

B The B cross reference on the DISPOSITION field (#.01) was created by VA FileMan and is used for lookups.

C This regular cross reference on the CODE field (#1) is used to facilitate the lookup process.

Cross References on Sub-Files:

SYNONYM (131.63)

D This MUMPS cross reference on the SYNONYM field (#.01) is used for lookups on the whole file.

OPERATING ROOM (131.7)

B The B cross reference on the NAME field was created by VA FileMan and is used for lookups.

Cross References on Sub-Files:

SERVICE BLOCKOUT (131.703)

B The B cross reference on the DAY field (#.01) was created by VA FileMan and is used for lookups within the sub-file.

SERVICE (131.704)

B The B cross reference on the SERVICE field (#.01) was created by VA FileMan and is used for lookups within the sub-file.

C The C cross reference on the SERVICE field (#.01) is used for lookups on the whole file.

START TIME (131.705)

B The B cross reference on the START TIME field (#.01) was created by VA FileMan and is used for lookups within the sub-file.

R The R cross reference on the END TIME field (#1) is used when creating, updating and deleting service blockouts from the operating room display graph.

SER The SER cross reference on the END TIME field (#1) is used when creating and updating the service blockouts for an operating room.

NORMAL DAILY SCHEDULE (131.711)

B The B cross reference on the DAY OF THE WEEK field (#.01) was created by VA FileMan and is used for doing lookups within the sub-file.

SURGERY UTILIZATION (131.8)

Cross References on Sub-Files:

OPERATING ROOM (131.81)

Trigger-Type Cross References:

START TIME (#1)
This trigger of the END TIME field (#2) deletes the END TIME when the START TIME is deleted.

START TIME (#1)

This trigger of the INACTIVE (Y/N) field (#3) functions to mark the operating room as active when a START TIME is entered and to mark the operating room as inactive when the START TIME is deleted.

SURGICAL SPECIALTY (131.82)

Trigger-Type Cross References:

START TIME (#1)
This trigger of the END TIME field (#2) deletes the END TIME when the START TIME is deleted.

START TIME (#1)
This trigger of the INACTIVE (Y/N) field (#3) functions to mark the surgical specialty as active when a START TIME is entered and to mark the specialty as inactive when the START TIME is deleted.

PROSTHESIS (131.9)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

SURGERY POSITION (132)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

RESTRAINTS AND POSITIONAL AIDS (132.05)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

SURGICAL DELAY (132.4)

B The B cross reference on the CAUSE field (#.01) was created by VA FileMan and is used for doing lookups in the file.

ANESTHESIA SUPERVISOR CODES (132.95)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the CODE field (#1) is used for doing lookups in the

file by CODE.

SURGERY SITE PARAMETERS (133)

B The B cross reference on the SITE field (#.01) was created by VA FileMan and is used for doing lookups.

Cross References on Sub-Files:

HOLIDAY SCHEDULING ALLOWED (133.027)

B The B cross reference on the HOLIDAY SCHEDULING ALLOWED field was created by VA FileMan and is used for doing lookups within the sub file.

REQUIRED FIELDS FOR SCHEDULING (133.028)

B The B cross reference on the REQUIRED FIELDS FOR SCHEDULING field (#.01) was created by VA FileMan and is used for doing lookups within the sub-file.

AC This MUMPS cross reference on the REQUIRED FIELDS FOR SCHEDULING field (#.01) automatically sets the FIELD NUMBER field.

MONITORS (133.4)

B The B cross reference on the NAME field was created by VA FileMan and is used for doing lookups in the file.

IRRIGATION (133.6)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the ABBREVIATION field (#1) is used for doing lookups in the file by the ABBREVIATION field.

SURGERY REPLACEMENT FLUIDS (133.7)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

SURGERY WAITING LIST (133.8)

B The B cross reference on the SURGICAL SPECIALTY field (#.01) was created by VA FileMan and is used for doing lookups in the file.

Cross References on Sub-Files:

PATIENT (133.801)

B The B cross reference on the PATIENT field (#.01) was created by VA FileMan and is used for doing lookups within the sub-file.

AP The AP cross reference on the PATIENT field (#.01) is used for sorting all patients on the waiting list.

AWL The AWL cross reference on the DATE ENTERED ON LIST field (#2) is used for sorting file entries by surgical specialty and by date entered on the waiting list for use in reporting.

REFERRING PHYSICIAN (133.8013)

B The B cross reference on the REFERRING PHYSICIAN field (#3) was created by VA FileMan and is used for doing lookups within the sub-file.

OPERATING ROOM TYPE (134)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

SURGERY CANCELLATION REASON (135)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the CODE field (#1) was created by VA FileMan and is used for doing lookups in the file by the CODE field.

SKIN PREP AGENTS (135.1)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the CODE field (#1) is used for doing lookups in the file by the CODE field.

SKIN INTEGRITY (135.2)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the CODE field (#1) is used for doing lookups in the file by the CODE field.

PATIENT MOOD (135.3)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the CODE field (#1) is used for doing lookups in the file by the CODE field.

PATIENT CONSCIOUSNESS (135.4)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the CODE field (#1) is used for doing lookups in the file by the CODE field.

SURGERY TRANSCRIPTION (136)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

PERIOPERATIVE OCCURRENCE CATEGORY (136.5)

B The B cross reference on the OCCURRENCE CATEGORY field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the SYNONYM field (#.01) of the SYNONYM multiple field (#3, sub-file #136.53) is used for doing lookups in the whole file by the SYNONYM field.

Cross References on Sub-Files:

SYNONYM (136.53)

B The B cross reference on the SYNONYM field (#.01) was created by VA FileMan and is used for doing lookups within the sub-file.

LOCAL SURGICAL SPECIALTY (137.45)

B1 The B1 cross reference on the NAME field (#.01) is used for doing lookups in the file.

C The C cross reference on the NATIONAL SURGICAL SPECIALTY field (#1) is used for doing lookups in the file.

D The D cross reference on the CODE field (#11) is used for doing lookups in the file.

ELECTROGROUND POSITIONS (138)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

C The C cross reference on the CODE field (#1) is used for doing lookups in the file.

RISK MODEL LAB TEST (139.2)

B The B cross reference on the NAME field (#.01) was created by VA FileMan and is used for doing lookups in the file.

Cross References on Sub-Files:

LABORATORY DATA NAME (139.21)

B The B cross reference on the LABORATORY DATA NAME field (#.01) was created by VA FileMan and is used for doing lookups within the sub file.

Archiving and Purging

Archiving

Version 3.0 of Surgery does not provide for the archiving of data.

Purging

The package does contain an option (Surgery Nightly Cleanup and Updates [SRTASK-NIGHT]) that should be tasked to run nightly that purges outstanding requests (those that have not been acted upon) older than 14 days, based upon the requested date of operation. Also, the package includes an option within the Utilization module for purging information from the SURGERY UTILIZATION file (#131.8) prior to the selected date.

External Relations

Packages Needed to Run Surgery

Surgery Version 3.0 relies (minimum) on the following external packages. This software is not included in this package and must be installed before this package is completely functional.

Package	Minimum version needed
Kernel	8.0
VA FileMan	21.0
MailMan	7.1
PIMS	5.3
Laboratory	5.2
Inpatient Medications	4.5
Pharmacy Data Management	1.0
Patient Care Encounter	1.0
Health Level Seven	1.5
Order Entry/Results Reporting	2.5

Calls Made by Surgery

Surgery Version 3.0 makes calls to the following external routines:

Routine	Entry Points Used
%DT	^%DT, DD
%DTC	^%DTC, C, DW, H, NOW
%RCR	%XY
%ZIS	^%ZIS
%ZISC	^%ZISC
%ZISS	ENDR, KILL
%ZOSV	$$EC, T0, T1
%ZTLOAD	^%ZTLOAD, $$S
AUPNVSIT	ADD, SUB
CSLSUR1	^BLDSEG
DDIOL	EN
DGPMDDCF	^ DGPMDDCF
DGUTL4	$$PTR2CODE
DIC	^DIC, LIST
DICD	WAIT
DICN	FILE
DICR	^DICR

DICRW	DT
DIE	^DIE, CHK, FILE, HELP, UPDATE, WP
DIK	^DIK, EN1, ENALL, IXALL
DIP	EN1
DIQ	$$GET1, D, EN, GETS, Y
DIQ1	EN
DIR	^DIR
DIU	DI
DIU2	EN
DIWP	^DIWP
GMRADPT	^GMRADPT
GMRVUTL	EN6
HLFNC	$$FMDATE, $$FMNAME, $$HLDATE
HLFNC2	INIT
HLMA	GENERATE
HLMA1	GENACK
HLTRANS	EN, EN1, INIT, KILL
ICPTAPIU	COPY
ICPTCOD	$$CPT, $$CPTD
ICPTMOD	$$MOD, $$MODP
LRBLB	BAR
LRBLBU	^LRBLBU
LRRP2	^LRRP2
ORX	FILE, RETURN, ST
PSGIU	END, ENS
PSIVACT	DCOR
PSSGIU	END, ENS
PXAPI	$$DATA2PCE, $$DELVFILE
SDCO21	CL
VADPT	^VADPT, ADD, DEM, ELIG, IN5, INP, KVA, OPD, SVC
VAFHLPID	$$EN
VBECA5A	ITRAN, LIST66, OUT66
XLFDT	$$FMADD
XLFSTR	$$LJ
XMA1C	REMSMSG
XMD	^XMD
XPDUTL	$$VERSION
XQALERT	DELETEA, SETUP
XUPARAM	$$KSP

Data Base Integration Agreements (DBIAs)

The Surgery package has Data Base Integration Agreements (DBIAs) with other packages. For complete information regarding DBIAs, please refer to the *DBA* [DBA] menu option on FORUM and then the *Integration Agreement Menu* [DBA IA ISC].

Internal Relations

All of the Surgery package options have been designed to stand alone. Each option requires the use of the package-wide variable array SRSITE that is set as users enter the package. Locally created menus containing Surgery package options will run more quickly if the following exit action and entry action are included in the Option file.

```
EXIT ACTION:  D EXIT^SROVAR
ENTRY ACTION:  D ^SROVAR
```

Generating On-line Documentation

Throughout the entire Surgery package, you may obtain on-line help. You may enter a question mark (?) at any prompt to assist you in your choice of actions.

The Data Dictionaries (DDs) are considered part of the on-line documentation for this software application. Use VA FileMan option #8 (LIST FILE ATTRIBUTES) to print the DDs. The following are the files for which you should print DDs:

#130	SURGERY
#131	PERSON FIELD RESTRICTION
#131.01	SURGERY TRANSPORTATION DEVICES
#131.2	SURGEONS' OPERATION TIMES
#131.25	OPERATION TIMES
#131.6	SURGERY DISPOSITION
#131.7	OPERATING ROOM
#131.8	SURGERY UTILIZATION
#131.9	PROSTHESIS
#132	SURGERY POSITION
#132.05	RESTRAINTS AND POSITIONAL AIDS
#132.4	SURGICAL DELAY
#132.95	ANESTHESIA SUPERVISOR CODES
#133	SURGERY SITE PARAMETERS
#133.4	MONITORS
#133.6	IRRIGATION
#133.7	SURGERY REPLACEMENT FLUIDS
#133.8	SURGERY WAITING LIST
#134	OPERATING ROOM TYPE
#135	SURGERY CANCELLATION REASON
#135.1	SKIN PREP AGENTS
#135.2	SKIN INTEGRITY
#135.3	PATIENT MOOD
#135.4	PATIENT CONSCIOUSNESS
#136	SURGERY TRANSCRIPTION
#136.5	PERIOPERATIVE OCCURRENCE CATEGORY
#137.45	LOCAL SURGICAL SPECIALTY
#138	ELECTROGROUND POSITIONS
#139.2	RISK MODEL LAB TEST

The namespace for the Surgery package is "SR."

Additional Information

Templates

The Surgery package includes input templates, one sort template and no print templates.

Input Templates

SREQUEST File #130
SRISK-MISC File #130
SRISK-NOCARD File #130
SRISK-NOCOMP File #130
SRNON-OR File #130
SRO-NOCOMP File #130
SRO-ROOM File #131.7
SROANES-AMIS File #130
SROCOMP File #130
SROMEN-ANES File #130
SROMEN-ANES TECH File #130
SROMEN-COMP File #130
SROMEN-OPER File #130
SROMEN-OUT File #130
SROMEN-PACU File #130
SROMEN-POST File #130
SROMEN-REFER File #130
SROMEN-STAFF File #130
SROMEN-START File #130
SROTHER File #130
SROVER File #130
SRPARAM133
SRSCHED-UNREQUESTED File #130
SRSREQV File #130
SRSRES-ENTRY File #130
SRSRES-SCHED File #130
SRSRES1 File #130
SRSRES2 File #130

Sort Template

SR BLOOD PRODUCT VERIFICATION File #19.081

Editing Input Templates

Input templates are used by package options that utilize the Surgery screen server to define the fields that are displayed for editing. These input templates may themselves be edited to add fields, to remove fields or to rearrange field display order. Below is a list of options used for entering operation or non-OR procedure information and the associated input templates used by the screen server.

Option	Template
Surgical Staff [SROMEN-STAFF]	SROMEN-STAFF
Operation Startup [SROMEN-START]	SROMEN-START
Operation [SROMEN-OP]	SROMEN-OPER
Operation (Short Screen) [SROMEN-OUT]	SROMEN-OUT
Post Operation [SROMEN-POST]	SROMEN-POST
Enter PAC(U) Information [SROMEN-PACU]	SROMEN-PACU
Edit Non-O.R. Procedure [SRONOP-EDIT]	SRNON-OR

Globals in the Surgery Package

The Surgery package stores data in the following globals:

^SRF
^SRO
^SRP
^SRS
^SRT
^SRU

Journaling Globals

The globals SR* are recommended for journalling.

Routine Mapping

The following routines are recommended for routine mapping, if possible.

SRCUSS*	SRONR*	SROPRP*
SROBLOD	SRONXR	SROPS
SROCON*	SROP	SROSR*
SROERR*	SROP1	SRORIN
SROMENU	SROPDEL	SRORESV
SRONIN*	SROPER	SRORUT
SRONO*	SROPERO*	SROSTOP
SRSAVL*	SROLOCK	SROUTIN
SRSBLOK	SROPRIN	SROVAR
SRSCAN*	SROPROC	SROX*
SRSCG	SRSIND	SRSTIME
SRSCH*	SRSKILL*	SRSUP1
SRSDIS*	SRSMREQ	SRSUPRQ
SRSDT	SRSREQ*	SRSUTL*
SRSGRPH	SRSRQ*	SRSWREQ

Resetting DTIME

The variable DTIME will be set to 3600 while in the Operation Menu [SROPER] options listed below. Most of the data entry for a surgical case is done in the operating room during the actual procedure. It is very important for the terminal to remain logged on at all times while in the operating room. Upon leaving each option DTIME will be restored to its original value.

Operation [SROMEN-OP]
Operation (Short Screen) [SROMEN-OUT]
Post Operation [SROMEN-POST]
Surgical Staff [SROMEN-STAFF]
Operation Startup [SROMEN-START]

Package-Wide Variables

The following Surgery namespaced local variables are package-wide variables.

SRSITE	This variable is the internal file number of the site in the SURGERY SITE PARAMETERS file (133).
SRSITE("AML")	This variable represents the mail code for the institution's anesthesia department as defined in the SURGERY SITE PARAMETERS file (133).
SRSITE("DIV")	This variable represents the division selected. It is the institution number in the INSTITUTION file (4).
SRSITE("IV")	This variable will equal 1 if IV orders are deleted upon admission to surgery. The value of this variable is derived from the SURGERY SITE PARAMETERS file (133).
SRSITE("NRPT")	This variable will equal 1 if the Nurse Intraoperative Report is to print all field titles. The value of this variable is derived from the SURGERY SITE PARAMETERS file (133).
SRSITE("OPTION")	This variable holds the internal file number of the entry option into the Surgery package. When this option is exited, the package-wide variables will be killed.
SRSITE("ORPT")	This variable will equal 1 if the Operation Report is to print all field titles. The value of this variable is derived from the SURGERY SITE PARAMETERS file (133).
SRSITE("REQ")	This variable represents the cut-off time for making operation requests as defined in the SURGERY SITE PARAMETERS file (133).
SRSITE("RISK")	This variable represents whether the Surgery Risk Assessment Module is being used. The value of this variable is derived from the SURGERY SITE PARAMETERS file (133).

SRSITE("SITE")	This variable represents the name of the institution in the INSTITUTION file (4).
SRTN	This variable is the internal entry number in the SURGERY file (130). It also serves as the case number.

The SRSITE array is set when the user enters the Surgery package and is killed upon exit from the package. This array stores values from the SURGERY SITE PARAMETERS file which may be referenced by the package.

SRTN is set when a case is selected for editing or review and is killed or re-set when another case is selected or when the user exits the menu or exits the package.

GLOSSARY

Glossary

Aborted Case status indicating the case was cancelled after the patient entered the operating room. Cases with ABORTED status must contain entries in TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232), plus CANCEL DATE field (#17) and/or CANCEL REASON field (#18).

ASA Class This is the American Society of Anesthesiologists classification relating to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.

Attending Code Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.

Blockout Graph Graph showing the availability of operating rooms.

Cancelled Case Case status indicating that an entry has been made in the CANCEL DATE field and/or the CANCEL REASON field without the patient entering the operating room.

CCSHS VA Center for Cooperative Studies in Health Services located at Hines, Illinois.

CICSP Continuous Improvement in Cardiac Surgery Program. It gives surgeons an on-line method for evaluating and tracking patient probability of operative mortality.

Completed Case Case status indicating that an entry has been made in the TIME PAT OUT OR field.

Concurrent Case A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.

CPT Code Also called Operation Code. CPT stands for Current Procedural Terminology.

CRT	Cathode ray tube display. A display device that uses a cathode ray tube.
Enter	To type in information on a keyboard and press the Enter key (or Return key for some keyboards) to send the information to the computer.
Intraoperative Ocurrence	Perioperative occurrence during the procedure.
Major	Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.
Minor	All operations not designated as Major.
New Surgical Case	A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.
Not Complete	Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232): 1) Case has entry in TIME PAT IN OR field (#.205). 2) Case has not been requested or scheduled.
NSQIP	National Surgical Quality Improvement Program.
Operation Code	Identifying code for reporting medical services and procedures performed by physicians. See CPT Code.
PACU	Post Anesthesia Care Unit.
Postoperative Occurrence	Perioperative occurrence following the procedure.
Procedure Occurrence	Occurrence related to a non-OR procedure.

Requested Operation has been slotted for a particular day but the time and operating room are not yet firm.

Risk Assessment Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the NSQIP or the CICSP national database for statistical analysis.

Scheduled Operation has both an operating room and a scheduled starting time, but the operation has not yet begun.

Screen An illuminated display surface on which display images are presented.

Screen Server A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery Package.

Screen Server Function The Screen Server prompt for data entry.

Service Blockouts The reservation of an operating room for a particular service on a recurring basis. The reservation is charted on a blockout graph.